

IJME 5th NATIONAL BIOETHICS CONFERENCE

Integrity in medical care, public health and health care research



INDIAN JOURNAL OF
MEDICAL ETHICS
JOURNAL OF THE FORUM FOR MEDICAL ETHICS SOCIETY SINCE 1993
ONLINE ISSN: 0975-5691 | PRINT ISSN: 0974-8466



Hosts and Organizers

St. John's National Academy of Health Sciences

Society for Community Health Awareness, Research and Action,

Forum for Medical Ethics Society, Mumbai

Preconference workshop 'Curriculum development for Integrated Teaching of Bio-ethics for medical and nursing students' on December 10, 2014

Preconference colloquium 'Ethical Perspectives in Gender in Health' on December 10, 2014

Parallel Arts Festival *supported by* 'Empathize Now' on December 11 to 12, 2014

International Symposium 'Corruption in Health Care and Medicine' co-organized by MEZIS, Germany on December 13, 2014

Conference Program, Introduction and Abstracts

St John's National Academy of Health Sciences, Bengaluru, December 11 to 13, 2014

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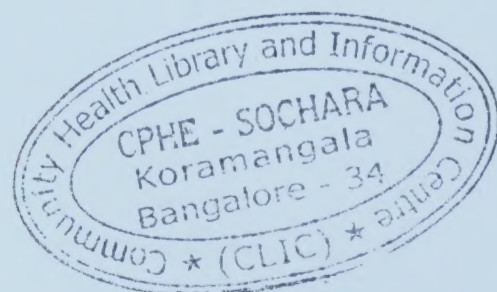
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14. Dr Sandhya Srinivasan, Consulting Editor Indian Journal Medical Ethics
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17. Dr Walter Vaz, Professor and Head of Forensic Medicine and Toxicology, Seth G S Medical College, Mumbai

Book of Abstracts compiled by: Dr Sunita Simon, Dr Marjorie Anna Mathew Correa, Dr Arpana Iyengar, Dr Priya Sreedaran, Dr Pragnashree Mukhopadhyay, Dr Arshiya Anjum



Introduction to the Fifth NBC: Integrity in medical care, public health and health care research

The Forum for Medical Ethics Society (FMES) has been organizing National Bioethics Conferences every two years – in Mumbai (2005), Bangalore (2007), Delhi (2010) and Hyderabad (2012). Each NBC has had the active participation of academic organizations, institutions providing healthcare, and nongovernmental organizations. The purpose of these conferences is to increase awareness and sensitivity in the research and practice of, and training in, bioethics; to sensitize and bring together individuals from various disciplines in health, social sciences and the humanities; to provide a platform for individuals and organizations to come together, share their work and give impetus to the development of bioethics as a discipline, and to facilitate activism for reforms in the health system using the frameworks of bioethics and human rights.

Following the last NBC at Hyderabad, members of both the FMES and the editorial board of *Indian Journal of Medical Ethics (IJME)* consulted widely with individuals and organizations in India and abroad. Many felt that the subject of corruption – and thus, integrity in health care and research practices – was an important issue that could be the theme for the Fifth NBC.

It was also pointed out that the theme of integrity would bring together mainstream healthcare and humanities professionals with civil society organizations and activists. The subthemes could be integrity and upholding patients' trust; the ethical imperatives of integrity in public health and healthcare research including publication; addressing conflict of interest in healthcare practices; and corruption in healthcare and medicine. It was decided that corruption could be a cross-cutting issue as well as a sub-theme of a special session on the nature of corruption in developed and developing countries, to be organized with international participants.

Rationale for the theme and sub-themes

Corruption has become a hotly debated issue in India in recent years, partly due to the availability of the Right to Information Act. Surveys such as by Transparency International have identified government health departments and healthcare institutions in India as among the top 'hotbeds' of corruption. The TV talk show '*Satyamev Jayate*' has also helped bring out problems in the private healthcare sector. All this has made the medical profession in India very defensive.

The past few decades have also seen an erosion of the public's trust in medical professionals and the entire healthcare system – a trust that is essential for the relationship between patient and provider. This has been repeatedly pointed out in the pages of the journal over the years. People's perception is that their best interests are not being taken care of, the system caters only to those who have the money, doctors are doing more for themselves and the healthcare industry than for their patients, and so on. So while people's vulnerability forces them to trust health professionals, it also makes them angry and frustrated when they feel that their trust has been violated. This perception is one important reason for the increasing violence against healthcare providers.

The move by the healthcare professions to lobby for special laws for their protection and to punish those who attack doctors is not enough. Nor is it enough to just address the immediate

triggers for violence, such as poor communication. There is a larger, systematic problem, that of an erosion of trust. There is a need for serious reflection on how to improve the integrity of the system and professional practices, and to restore trust.

Need for reflection and improvement

In short, in the last several years, issues related to the integrity of health professionals and services have found center stage in the public debate. The focus so far has been on violations by healthcare professionals, the suffering this causes, the perception of deception and distrust, and so on. The media has often sensationalized it, activists sometimes talk of a conspiracy to rob people of their rights, and the solutions suggested are often about punishing those who got caught.

While this conference will acknowledge that the emphasis on violations has created awareness among people about the issue, and the profession and services have come under pressure, it will not be a mere discussion on the negative aspects of the situation. It will encourage presentations and discussions that enable participants to reflect on this state of affairs, encourage them to look for good practices, and apply their minds on how to build a system that will arrest and reverse this downslide of integrity in the profession and the healthcare system.

Amar Jesani

Indian Journal of Medical Ethics

The Indian Journal of Medical Ethics, published since 1993 by the Forum for Medical Ethics Society, is an independent peer-reviewed academic journal providing a platform for publication of original research material and discussion on all aspects of healthcare ethics, bioethics and the humanities, relevant to and/or from the perspective of India and other developing countries. The journal promotes multi-disciplinary and multi-cultural inquiry by academics as well as activists from the fields of bio-medicine, social sciences, law and humanities. It strives to involve all cadres of, and beneficiaries of the healthcare system, and strengthen the hands of those with ethical values and concern for the underprivileged. Since the year 2000, the journal has an online edition published on its website (www.ijme.in) as well as a print edition.

In 2005, the US National Libraries of Medicine (PubMed) decided to index all previous issues (starting from the first issue in 1993) and also start prospective indexing of IJME. Since its inception, the IJME has not charged authors for publication of their writings, and all material available on the website of the journal is free and offers open access to all. The journal is primarily sustained by donations and grants received from individuals and philanthropic organizations, and by a subscription fee charged for its print edition. IJME has acted as a valuable resource of teaching material for ethics courses in academic and clinical healthcare institutions.

Forum for Medical Ethics Society (FMES)

The Forum for Medical Ethics Society (FMES) is a voluntary non-profit organization, set in 1989 in Mumbai, by a group of concerned activists and health professionals to focus attention on the need for ethical norms and practices in healthcare in India. It owns and publishes the Indian Journal of Medical Ethics, an independent peer-reviewed open access journal for the publication of research in the developing world in the neglected areas of healthcare ethics, bioethics, and human rights; and for provision of a platform for reflection, debate and the coming together of people actively interested in the improvement of the healthcare system.

It has involved concerned healthcare professionals, along with those from allied fields such as the social sciences, humanities and law, and activists from civil society, in working together towards the equitable provision of good healthcare. Beginning with a small group in Mumbai, the FMES has, at present, 41 highly committed individuals from different disciplines and organizations as core members at the national level. From 2005 onwards, the FMES has helped organize four National Bioethics Conferences, on the themes Ethical challenges in biomedical and social science research, and The ethical responsibilities of clinical care providers (2005, Mumbai); Moral and ethical imperatives of healthcare technologies (2007, Bangalore); Governance in healthcare (2010, New Delhi); and Ethics and regulatory challenges in health research (2012, Hyderabad). The FMES has also facilitated the production of bioethics and medical ethics literature in India. Its members have been involved in setting up, running or providing assistance in teaching/training programs, as resource persons for short courses in ethics as well as post-graduate diploma courses in ethics at various institutions in India, Bangladesh, and Pakistan.

SOCHARA

The Society for Community Health Awareness, Research and Action (SOCHARA) is a professional resource group in community health and public health, rooted in civil society. It has spearheaded community health action; innovative training; and health policy action research in community health and public health since the inception of CHC in 1984. SOCHARA was registered in 1991 building on the work of the Community Health Cell (CHC) which is its functional unit. It is headquartered in Bengaluru, Karnataka, with team clusters in Chennai, Tamil Nadu and Bhopal, Madhya Pradesh. Since 2011 the SOCHARA School of Public Health, Equity and Action (SOPHEA) evolved building on community health learning programs that are run since 2003.

SOCHARA brings to the fore a broader sense of 'community' and a 'societal determinants perspective' on health.

- This paradigm shift envisages a shift from a bio-medical to a socio-community approach to public health
- A continuum from individual to community
- A shift from seeing people as patients or beneficiaries to people as equal participants
- A move from providing to empowering and enabling
- From drugs and technology to educational and social processes
- Professional control to demystification and social control.

The SOCHARA Objectives are:

- To create awareness regarding the principles and practice of community health
- To promote and support community health action through voluntary and government initiatives
- To undertake research in community health policy issues
- To evolve educational strategies for community health and development
- To dialogue and participate with all stakeholders to enable formulation of community oriented health strategies
- To establish a community health library and information center.

SOCHARA brings to the fore a broader sense of 'community' and a 'societal determinants perspective' on health. The SOCHARA team worked with the Rajiv Gandhi University of Health Sciences, Karnataka helping facilitate the introduction of Medical Ethics into the undergraduate medical curriculum through an Ordinance in 1997-98. The SOCHARA founder President the late Dr. CM Francis authored a book on Medical Ethics which was later prescribed as the textbook by the University. More recently SOCHARA facilitated the introduction of Values into the MPH (Hon) curriculum, which includes integrity, equity, rights, gender and quality.

St John's National Academy of Health Sciences

St John's National Academy of Health Sciences is run by the Catholic Bishops Conference of India (CBCI). Started as a Medical College in 1963, the idea of a Catholic Medical College in India can be traced to a doctor-nun missionary, Dr. Sr. Mary Glowrey, who was overwhelmed by the task of caring for poor women and children, leprosy patients and the downtrodden. She was convinced that a Catholic Medical College would allow doctors to be trained who would work in increasingly large number of Catholic dispensaries/hospitals in rural and remote areas where doctors at that time were not willing to work. This idea was converted into reality by the efforts of the CBCI who steered the project through extremely difficult circumstances. The main purpose of St. John's was to train health care personnel who would serve in the under reached areas of our country.

St. John's was conceived as a national institution drawing students and faculty from across India in a symbol of national integration. The institution strives to work with integrity and compassion, sensitive to issues of equity and driven by a sense of excellence. With this objective, St. John's introduced ethics in medical education from its inception in 1963. It has been a pioneer in ethics education in the country. Its curriculum has been accepted by many institutions in India. In 1971, students and young interns responded to the first large external crisis that St. John's faced – the refugee camps during the Bangladesh war. Since then the Disaster Response Team has reacted to every major natural disaster in India.

The campus, spread over an area of 132 acres, consists of a Medical College, a state of the art Hospital with 1200 beds for all medical and surgical departments including super-specialty departments, a College of Nursing, a Research Institute and an Institute of Health Care Management and Paramedical Studies. St. John's Research Institute was first research institution in the country to be located in a medical college. The Institute also has a Biorepository. Health and Humanities has been established as a separate division. All these efforts are to make its students harmonize dedication to excellence with commitment to social justice in health care. St. John's has been involved in the previous National bioethics conferences as a partner and now the 5th National Bioethics conference is being held in its vibrant campus.

FELICITATIONS
Marthanda Varma Sankaran Valiathan



The 5th National Bioethics conference has decided to felicitate Dr. M. S. Valiathan for his distinguished service to the cause of medicine and medical ethics. Prof. Valiathan was born on 24th May 1934 in Mavelikara, to Marthanda Varma and Janaki. He obtained his FRCS in 1960 and a MS from the University of Liverpool two years later. After a brief stint as a faculty member at the PGIMER- Chandigarh, India; he underwent further training in cardiac surgery at the Johns Hopkins, in the United States. He received the Fellowship of the Canadian Royal College in cardiac surgery in 1970.

Professor Valiathan served on the faculties of the Georgetown University Hospital, Washington; PGIMER Chandigarh and IIT, Chennai before moving to Trivandrum as the architect of the Sree Chitra Thirunal Institute, where he remained as Professor of Cardiac Surgery and Director for twenty years. After leaving the institute, Professor Valiathan served as the first Vice-Chancellor of the Manipal University. Prof. Valiathan is known for merging engineering and medicine. He and his team at Sri Chitra Thirunal developed the indigenous affordable, prosthetic valves for cardiac surgery and as series of devices such as blood bag, oxygenator and cardiomy reservoir, and a vascular graft.

Prof. Valiathan is a recipient of numerous national and international awards. He received the Padma Vibhushan from the Government of India in 2005. He is a Past-President of the Indian National Science Academy, Association of Indian Universities, Chairman of the National Bioethics Committee of the ICMR, and currently, a National Research Professor engaged in promoting research in basic science, based on cues from Ayurvedic concepts and procedures. He has authored several books and scientific articles.

Prof. Valiathan has been the chairman of National Bioethics commission. His major contribution to ethics has been resurrection of Ethical practices in Ayurveda. His classics on *Suśruta* and *Charaka* have highlighted the ethical practices and principles that were prevalent in Ancient India. As the head of Sri Chitra Thirunal institute and also as a vice- chancellor of Manipal University he has been in forefront of upholding ethical practices and in being a role model for many younger generations. He embodies the walk the talk in medical ethics

FELICITATIONS
Dr Farhat Moazam



Dr Farhat Moazam studied medicine at the Dow Medical College, Karachi, Pakistan and later in the US, qualifying at the American Board of Surgery with a special competence in paediatric surgery. She returned to Karachi in 1985 to set up the department of surgery at the Aga Khan University (AKU), where she also happened to be the first woman surgeon. She was *Quaid-e-Azam* Professor of Surgery and Chief of Surgery at AKU from 1985 to 2000, as well as associate dean of postgraduate medical education at the faculty of health sciences at AKU 1995-2000. As a surgeon in Pakistan, Dr Moazam was always acutely aware of the conflicts intrinsic to healthcare in Pakistan and other countries in South Asia, and the inadequacy of the western model of ethics for the unique needs of the region where family structures and religion can play an important role in people's lives. This led her to a doctoral programme in bioethics, looking at bioethics and organ transplant in a Muslim society, which she conducted at the Sind Institute for Urology and Transplantation (SIUT), a unique government-supported organisation that provides dialysis and transplant free of cost. She spent several months there in 2001, interviewing patients, their families, health professionals and social workers. Here, she got to know SIUT's founder and director, Dr Adib Rizvi, who was so impressed by her that he asked her to consider setting up a centre of ethics at the institute. The same year that she completed her PhD, Dr Moazam came back to Karachi to set up the Centre of Biomedical Ethics and Culture (CBEC), Pakistan's first and only bioethics centre, and run entirely on locally generated funds from SIUT.

Through a rigorous training programme, CBEC hopes to infuse ethics into medical education and practice in Pakistan. In 2012, CBEC started workshops on ethics for schoolteachers and high school students in an effort to broaden the reach of bioethics beyond the healthcare professions. In addition to her primary responsibility as professor and founding chairperson of the Centre for Biomedical Ethics and Culture, Dr Moazam is Fellow of the Institute of Practical Ethics and Visiting Professor of the Centre for Humanism in Medicine, University of Virginia, Charlottesville, Virginia, USA; Fellow of The Hastings Center, NY, USA; and Board Member of the International Association of Bioethics. Since 2011, she is also a member of the National Bioethics Committee of Pakistan, and, since 2012, chair of the Healthcare Ethics Committee, where she has been involved in developing guidelines for a bioethics curriculum for medical schools. Of special importance has been her work on ethical challenges in organ transplantation in Pakistan, highlighting how cultural and religious practices can either enable or sabotage a programme. Dr Moazam has also been at the forefront of the international campaign against organ trafficking and fought tenaciously against the organ trade in Pakistan. She was instrumental in the passage of the Human Organ Transplant Law in 2007. Dr Moazam has also worked to mentor her junior colleagues in the conduct of research and writing in bioethics, contributing to their personal growth as well as of the discipline. On the occasion of the Fifth National Bioethics Conference of the *Indian Journal of Medical Ethics*, we are privileged to honour Dr Farhat Moazam for her life's work in the promotion of bioethics education, her efforts to support ethical organ transplantation programmes, as well as her contributions to the campaign against the organ trade in South Asia.

5th National Bioethics Conference, Dec 11-13, 2014

Venue: St. John's Medical College, Bengaluru

PROGRAM

DATE	SESSION	EVENT	SPEAKERS/ORGANIZER'S
Wednesday 10 th Dec 2014	1. PRE CONFERENCE WORKSHOP	<u>Theme:</u> Curriculum Development for Integrated Teaching of Bio-Ethics for medical and nursing students	St. John's Medical College -Dept. of Medical Education with Christian Medical College, Vellore
	2. PRE CONFERENCE COLLOQUIUM	<u>Theme:</u> Ethical Perspectives on Gender in Health	A Collective with St. John's, Sama, SOCHARA and Women's Movement members
Thursday 11 th Dec 2014	PLENARY - I		
	Introduction to the NBC and its theme Welcome comments	The contribution of IJME and FMES to Bio-ethics & the theme of this NBC Medical and Research Ethics in St John's	Dr Amar Jesani FMES/Indian Journal of Medical Ethics Rev Dr Paul Parathazham Director, St John's
09.00am to 11.00	Keynote address -1	Topic: Ethics: Between Event and Philosophy	Prof. Shiv Visvanathan Professor, School of Government and Public Policy, O. P.

Co Chairs: Dr Thelma Narayan Dr GD Ravindran			Jindal Global University
	Keynote address -2	Topic: The Dualism of Bio-medicine: A Cartesian Heritage	Prof. Farhat Moazam Prof & Founding Chairperson, Centre of Biomedical Ethics and Culture (CBEC) of Sindh Institute of Urology and Transplantation in Karachi, Pakistan
		Felicitations : NBC Honors Prof. Farhat Moazam and Prof. M Sankaran Valiathan Vote of thanks and announcements	
11.00m to 11.30am	Tea-break		
11.30am to 01.00 pm	PARALLEL PAPER PRESENTATION SESSIONS – I	Ethics of Disclosure Research Ethics 1 Public Health Ethics 1 Ethics of Care Ethics and Reproductive Health Corruption in Health Care and Research	
01.00pm to 2.00 pm	Lunch		
02.00pm to 4.00pm	PARALLEL WORKSHOPS – I	Balancing act of Caring: Boundaries in Health Care Practice Professional and civil society perspectives on challenges and approaches in ethical practice of	

		<p>occupational health in India</p> <p>Research on stored biological samples and medical records</p> <p>Preventing overdiagnosis: targeting drivers of too much medicine</p> <p>Watching Bioethics</p>	
04.00pm to 04.30pm	Tea-break		
	PLENARY II		
04:30pm to 06.30 pm Co Chairs: Dr Mohan Isaac Sandhya Srinivasan	Sub-theme: <i>“Integrity in clinical practice”</i>	20 minutes each: After presentations are over, discussion for 30 minutes), summing up (10 minutes) Co-chairs	
	Keynote address	Topic 1: Ethics as an essential element in evidence and health policy	Dr. Anura Kurpad Professor of Physiology , St. John’s National Academy of Medical Sciences
	Keynote address	Topic 2: Epidemic of “Cut practice” in general and “Private practice” Their consequences for ethics and integrity in medical care and the conflicts of medical and business ethics in healthcare organizations and practices.	Dr. Om Prakash Honorary Emeritus Consultant in Medicine, St. Martha’s Hospital, Bangalore
	Keynote address	Topic 3: Role of professional councils and health care regulators in upholding integrity of medical care	Dr Sanjay Nagral Dept of Surgical Gastroenterology, Jaslok Hospital & Research Centre, Mumbai
	Discussion (30 min)	Chairpersons’ remarks & Summing up (10 min)	
7.00 pm	EVENING PROGRAMME (Venue: Nursing	Three short (10/15min) plays on empathy in healthcare	Empathize Now with Ms. Anita Mithra,

	Auditorium)		Bangalore
Friday 12th Dec, 2014	PLENARY - III		
09.00am- 11.00am Co-Chairs Dr Mala Ramanathan Dr Arvind Kasthuri	Sub-theme: “Integrity in public health practice and the health system”	20 minutes each, followed by discussion 30 min., summing up (10 minutes) Co-chairs	
	Keynote address	Topic 1: Integrity in Public Health: Systemic Challenges and Policy Paradigms	Dr. Ravi Narayan Senior Community Health Consultant - SOCHARA in-charge
	Keynote address	Topic 2: Integrity in access to public health services with a specific focus on gender and reproductive health	Ms. N B Sarojini Sama Resource Group for Women and Health
	Keynote address	Topic 3: Crisis in education of health: Ethical challenges in upholding scientific and moral integrity	Dr. Anand Zachariah Prof of Medicine CMC Vellore
	Discussion	Chairpersons’ remarks and summing up	
11.00am- 11.30am	Tea-break		
11.30am to 1.00pm	PARALLEL PAPER PRESENTATION SESSIONS - II	Research Ethics 2 Ethics and Pharma industry Public Health Ethics 2 Trust, Integrity and Social Stigma Clinical Ethics Ethics and Gender	
01.00pm to 02.00pm	Lunch	POSTER PRESENTATIONS Main auditorium Foyer	

	PARALLEL WORKSHOPS - II	Clinical Ethics Committee: A way to promote ethical practice Clinical Ethics Case consultation Public Health Ethics Good Authorship Practices- Filling in the gap	
04.00pm to 04.30pm	Tea-break		
	PLENARY - IV		
04.30 pm to 06.30pm Co-Chairs Dr. Vasantha Muthuswamy Dr. Sanjay Pai	Sub-theme: “Scientific integrity and misconduct in clinical and public health research”	20 minutes each, followed by discussion (30 minutes)	
	Keynote address	Topic 1: Scientific misconduct: Human rights violation of participants, Plagiarism, ghost writing, Data fabrication and falsification and publication ethics	Dr. Peush Sahni Professor, Department of Gastrointestinal Surgery and Liver Transplantation, All India Institute of Medical Sciences; Editor, The National Medical Journal of India
	Keynote address	Topic 2: Conflict of Interests in health care and research	Dr. Roli Mathur Scientist D, Indian Council of Medical Research
	Keynote address	Topic 3: Research Ethics guidelines and regulations for upholding integrity of research and protection of whistle blowers: Ethics committees, research regulators and office of scientific integrity	Dr. Nandini Kumar Former Deputy Director General Sr. Grade (ICMR); Dr. TMA Pai Endowment Chair, Manipal University; Adjunct Prof. Kasturba Medical College, Manipal
	Discussion	Chairpersons’ remarks & Summing up	

Saturday 13th Dec, 2014	PLENARY – V		
09.00am to 10.30am Co-Chairs: Dr. Christiane Fischer Dr. George Thomas	Sub theme: <i>International Symposium on Corruption in health care and medicine</i>		
	Key note address	Topic 1: Corruption & conflict of interest in health care and medicine	Dr. Sujatha Rao Former Union Health Secretary, India, IAS (retd)
	Keynote address	Topic 2: What can we do about temptation and bias?	Dr. Peter Mansfield General Practitioner, Australia; and Healthy Skepticism
	Testimonies: (5 minutes each)		Dr. Susan Abdelrahman Researcher at Institute of Biomedical Ethics, University of Zurich, Sheffield, UK Dr. Joseph Sawyer Physician, NHS London, UK Dr. Rajan Madhok Manchester, UK Ms. NB Sarojini SAMA, India & PHM Global Co-chair
		Discussion Chairpersons' remarks	
10:30am to 11:00am	Tea-break		
11.00am to 01.00pm	PARALLEL WORKSHOPS - III	Corruption in health care-Working towards solutions WHO session on integrity and corruption in health care Accountability for Reasonableness:	

		<p>Addressing Challenges in Public Health by harmonizing Ethics, Economics and Evidence</p> <p>The Internet and Digital Ethics: New challenges for practitioners and Clients</p> <p>Creating a more Globally inclusive Ethics</p>	
01.00pm to 02.00pm	Lunch		
02.00am-03.30pm Co-Chairs: Dr. Christiane Fischer Dr. Nina Urwantzoff	Panel Discussion	<p>Just a gift?</p> <p>The influence of pharmaceutical marketing activities on prescription behavior</p>	<p><u>Panel Discussants:</u></p> <p>Dr. Subrata Chattopadhyaya Professor of physiology, College of Medicine and Jawaharlal Nehru Memorial Hospital, Kolkata</p> <p>Dr. Susan Kamal Abdelrahman Researcher at Institute of Biomedical Ethics, University of Zurich, Sheffield, UK</p> <p>Dr Aamir Jafri Associate Professor, Centre of Biomedical Ethics and Culture, Sindh Institute of Urological Transplants</p> <p>Dr. Robyna Irshad Khan Director Pain Fellowship Program, Department of</p>

			Anaesthesiology , Aga Khan University
03.30 to 04.30	Conference Closure And Vote of Thanks	1) Summary of Conference 2) Comments on Future Action	Dr. Sunita Simon Kurpad; Dr. Ananth Bhan; Mr. Prasanna Saligrama Dr. Amar Jesani Dr. Christiane Fischer Dr Thelma Narayan Dr GD Ravindran
04.30pm	TEA		

All plenary sessions and the panel discussion of the third day will be held in the Main auditorium

Parallel Arts Festival

11:30-1:00	FILM VIEWING	
POPE PAUL VI Auditorium	<i>December 11</i> 1. Petals in the Dust 2. The Human cost of Health Care	<i>December 12</i> 1. Love, Hate and Everything In Between
1:00-2:00		
2:00-4:00	FILM VIEWING	
POPE PAUL VI Auditorium	<i>December 11</i> 1. Fire in the Blood	<i>December 12</i> 1. The English Surgeon
4:00-4:30	Tea Break	
4:30-6:30 Main Audi	Plenary Session II	Plenary Session IV
Nursing Auditorium 7:00	Short Plays	

Free arts festival at 5th National Bioethics Conference

The program is being organized by *Empathize Now!* (<http://empathizenow.com/>),an initiative to advocate the role of empathy in prompting positive social change.

Summary of films: 11th December, 2014

Venue: Pope Paul VI Auditorium (A discussion with the audience and a select panel, including directors of some of the films, will follow after the screenings),

11.30 am: *The Human Cost of Healthcare:* Many medical products used by the National Health Service in the UK are made in the developing world where workers are exposed to hazardous conditions, risking serious injury and even death. This film questions the ethics behind the NHS supply chain – how do you justify risking lives to save lives? (12min, produced by British Medical Association)

“It is difficult not to be moved by the personal stories of workers injured in the manufacture of surgical instruments used in the NHS. But how do you translate the feelings of empathy and concern into action?” – Guardian, UK

11.45 am: *Petals in the Dust – The Endangered Indian Girls* A powerful trailer of a movie in the making. It highlights how age-old beliefs and a preference for sons, combined with growing materialism and technology is leading to increased incidences of discrimination and violence against Indian girls and women, 7,000 of whom are murdered every day. (7 mins, director: Nyna Pais Caputi)

2pm: ***Fire in the Blood***: An intricate tale of medicine, monopoly and malice, it tells the story of how Western pharmaceutical companies aggressively blocked access to low-cost AIDS drugs for Africa and Asia resulting in 10million unnecessary deaths – and the remarkable coalition that came together to battle against this blockade. (89mins, director: Dylan Mohan Gray, India)

“hard-hitting! systematically exposes how patents enabled Western pharma corporations to increase their profits while millions of people in the developing world lost their lives... A must-see for the medical community, especially in India” – British Medical Journal

Summary of plays

Venue: Nursing College Auditorium, DECEMBER 11, 7pm

These plays have been specially written for the 5th NBC. Mahesh Dattani, India’s foremost English playwright has reviewed the final drafts and Tortilla Entertainment Company is directing the production. A discussion with the audience and a select panel will follow after the performances.

A Heart to Heart: A patient in touch with his body – and the Internet – insists he knows what is wrong with him, even though his doctor would have him believe otherwise. (Playwright: Kusum Punjabi)

MPL: Here the adage ‘*health is wealth*’ is taken literally – where the best medical services go to the highest bidder (Playwright: Adarsh Satish)

Can You Feel This? Will diagnosis of a disease from inexplicable symptoms require the ear of a doctor at all? (Playwright: Deepak Hariharan)

Summary of Films: 12th December, 2014:

11.30am: ***Love, Hate & Everything In Between***: Man's capacity for kindness and compassion is overshadowed only by his ability to be as cruel and destructive. Can empathy solve issues of aggression, segregation and subjugation, where wars, politics and economic sanctions have failed? The film looks into the fields of neuroscience, psychology, education and technology to explore the extraordinary relevance of empathy in today's increasingly interconnected world. (52mins, director: Alex Gabbay, UK)

"Love, Hate and Everything In Between is a critical and insightful contribution to the conversation about the value and impact of a more empathic civilization." - Paul O'Hara, Director, Ashoka Europe

2pm: ***The English Surgeon***: Shot in an Ukranian hospital full of desperate patients and makeshift equipment, this award-winning BBC film is an intimate portrait of brain surgeon Henry Marsh as he wrestles with the dilemma of the doctor-patient relationship. Tense, heartbreaking and humorous, it is a remarkable depiction of one doctor’s commitment to relieving suffering and the emotional turmoil he undergoes in bringing hope to a desperate people. (94mins, director: Geoffrey Smith, UK)

“Astonishing! these men perform miracles but they are also agonizingly human” – The New York Times

Dolls exhibition

Venue: 1st floor, Humanities **December 11: Noon to 6.30pm; December 12-13: 9am to 6.30pm**

The Dolls Speak – Listen!: Francioise Bosteels, a Belgian nurse who has made India her home, exhibits about 80 miniature dolls she has made over a period of 35 years. Inspired by the real life stories of despair and hope that her dolls depict, it is the viewer’s empathic response to what her dolls say that motivates Bosteels to pick up her needle and thread over and over again.

Pre-Conference Workshop, 10th December 2014

Medical Education Workshop: Integrated Teaching of Ethics

Organized by St. John's Departments of Medical Ethics and Medical Education and Christian Medical College, Vellore

Introduction:

Ethics in our professional practice and during our roles and responsibilities as health care providers is what categorizes us as Professionals. It is during education (graduate and post-graduate) that Ethics will need to be learnt (hence, taught). In our present system, it is common that apart from some mandatory lectures most ethics "teaching-learning" occurs informally through role models is not always structured neither a planned educational experience with clear outcomes. An effort to systematically plan an outcome based curriculum relevant and feasible to the existing medical course is the primary objective.

Workshop Outcome:

By the end of the Workshop Medical and Nursing Educational Institutes would have developed a draft curriculum that facilitates the process of learning and teaching ethics relevant for their own settings.

Intermediate Objectives

- will jointly publish the challenges towards developing a medical ethics curriculum in an indexed journal.
- would have developed a network that enables a continued support towards learning and teaching medical ethics through sharing between institutions.
- would have developed a resource library that enables a continued support towards learning and teaching medical ethics through sharing between institutions.

Anticipated Participants: (Total number is limited to 25-30 participants)

Medical Faculty of Teaching Institutions, nominated by Dean/Principals, preferably as a team of two. At least, one faculty with a Medical education background would be optimal. Teams will be selected based on a first come first come and need basis keeping in mind a healthy regional distribution. Individuals who are not attached to academic institutions will not be discouraged and attempts will be made to place them into existing teams.

Organising Team:

Department of Medical Education, St. John's Medical College, Bangalore

Drs. John Stephen, Suneetha N, Mary Joseph, Shirley George, Nachiket Shankar, Shobha Nair, Maria Pauline, Ms Matcy, Lakshmi TA, Sanjiv Lewin

Division of Bioethics, Christian Medical College, Vellore

Drs. Anuradha Rose, Anna Benjamin Pulimood, Kuryan George, Rev Arul Dhas

Department of Ethics, St. John's Medical College, Bangalore

Drs. GD Ravindran, Sanjiv Lewin, Sunita Simon Kurpad, Shakuntala

Colloquium on ETHICAL PERSPECTIVES IN GENDER IN HEALTH “ ,

Date : Wednesday 10th December 2014, 9.30 am to 5 pm

Venue : Annex III, St. John's National Academy of Health Sciences.

The Women's Movement has been addressing the core issue of gender inequity underpinned by patriarchy that crosscuts all aspects of life of the entire population affecting individuals, families, communities and society at large. This effort has evolved in recent decades into a larger social movement for gender and social justice. Health and health care have also been increasingly part of this process of transformation and change. The role of medical technology and of the medical and health professions have come under the scanner and debates rage about the adverse effects of certain practices on health and well-being.

Gender issues in health, health care, medicine and research are many. They include adverse gender ratio's, lack of effective regulation and poor quality of reproductive health care, maternal mortality that continues to be high because of lack of good pre-natal care and facilities for safe deliveries for many communities and populations, inadequate support systems and safety for women health workers who comprise the majority in the health human resource pool, loss of autonomy, absence of voice in decision and policy making.

An enormous amount of work and effort has gone into addressing and redressing some issues. Women's groups have adopted a Women's Health Charter in 2007. The People's Health Movements (PHM) and Jan Swasthya Abhiyan (JSA) have a Campaign against Female Feticide. LGBTs struggle for justice and voice and to sensitize the health care system to their needs for dignity and access to care. The National Rural Health Mission has made some progress with regard to increasing access to maternal and reproductive health care. However the gaps are huge and human rights violations continue as is evident from the horrific incident in Bilaspur. Pressure to meet family planning targets continue in many states despite signing of international conventions and the passing of government orders. Efforts towards gender sensitization of the public health system are underway and at a very early stage.

This one day Colloquium offers an opportunity for an experienced and committed group to come together to reflect on the ethical perspectives and considerations in Gender in Health and see how this can be taken forward in health action, education and research. It will be conducted in the form of an Open House.

Lead discussants will share their thoughts on particular topics for about 10 minutes followed by a moderated discussion. The views of each participant are valuable and we will together ensure that all voices are heard.

Sessions will focus on a current situation analysis; a perspective of the issue from an ethics lens, leading to a few points towards strengthening the movement of Gender Justice in Health: an Ethical Approach.

Organiser: **Prof Elizabeth Vallikad**, Co-organiser: **Dr Jyothi Idiculla**

Abstracts Day One: 11th December, 2014

Oral papers: 11:30 am to 1:00 pm

- *Ethics of Disclosure: Venue –Main auditorium Mtg Room 1*

O-Relooking At The Need For Disclosure: The Play of “Knowing” & “Not-Knowing” In The Terminally Ill

Meghna Mukherjee

This research attempts to re-evaluate the dominant practice of universal disclosure of the patient’s prognosis in our cultural context. The research included seventeen adult terminally ill participants diagnosed with cancer, all aware of their diagnosis. They were further divided into two groups. The first group comprised of ten participants who were “unaware” of their terminal condition while the second group comprised of seven participants who were “aware” of the same. The emphasis of the research was to understand and document the phenomenological experiences of “knowing” and “not knowing” (the prognosis) in the participants and the consequent impact on their psychological well-being. Research method: This research attempted to incorporate both quantitative and qualitative dimensions to represent the participant’s experiences. However the major theoretical approach used for collecting and analyzing data borrows heavily from the phenomenological approach, which is a discovery-oriented qualitative approach. The WHO (Ten) Well-Being Index was administered to obtain an objective score of their well-being levels and in-depth “interactions” inspired by ethnographic investigations were conducted with the participants multiple times over the course of two months to capture their lived experiences. The only intervention used was “listening” which proved to be a cathartic experience for most of the participants. This research was reviewed by the ethics committee of the institution of data collection and informed consent was taken from all the participants and their identity was kept confidential. Results: The statistical analysis (t-test) of the Well-Being Index scores revealed no significant difference in the well-being levels of participants between the two groups. The “interactions” with the participants in the two groups were analyzed and grouped into “themes” revealing qualitative differences in the way the participants coped and perceived their illness, highlighting the importance of caregiver’s acceptance and tolerance of their loved one’s condition as imperative for the patient to tolerate their own prognosis. Implications: This research reveals that “knowingness” and “unknowingness” of prognosis are complex states and the decision to disclose the patient’s prognosis needs to be taken on a case by case basis rather than following the ethics of universal disclosure

O-Revelations and Disclosures: ethical dilemmas arising in context of imparting psychoeducation to spouse

Priya Sreedaran, Bala Shanti Nikketha

Psychoeducation refers to a specific non-pharmacological therapeutic intervention aiming to improve the coping of clients with mental illnesses and their families by imparting education to them about their condition. In India where arranged marriages are still common, past history of mental illness in a person is usually not revealed to the prospective marital partner. In such cases, mental health professionals often face the dilemma about the amount of information that is needed to be imparted to spouse of patient as part of psychoeducation. This dilemma assumes

significance as the spouse often also assumes role of primary care-giver. The ethical issues that arise in this context are discussed with respect to the four principles approach using a case report format.

O-Truth Telling and Therapeutic Privilege: Exploring the Conflicts

Supriya Subramani

Present day patient centric health care is all set for upholding “Patient Autonomy”. In order to respect “Patient Autonomy”, one has to provide information. Consent process demand physician to provide information in order to empower patients to make choices. In this process physician is supposed to tell the truth and disclose information relating to patient’s health, treatment options and risks. On the one hand “Truth Telling” is reflected as an essential part of professional integrity. Law identifies on the other hand the concept of “therapeutic privilege”, where the information is withheld to patient as it may affect patient’s health and wellbeing. Here the physician acts in the best interests of patient. Though both truth telling and withholding information have evolved for the benefit of the patients, there are situations where these concepts are in direct conflict. Firstly, is omitting important information distinguishable from telling lie or incorrect information; secondly did the physician know he was telling untruth and was he doing so deliberately; thirdly should the physician’s motivation be questioned? This suggests a debate on honesty which is part of professional integrity. It demands attention because of the lack of consensus among physicians, ethicists and in case laws on information disclosure and therapeutic privilege. In the era of acceptance of informed consent as ethical doctrine and legal concept, these concepts need further exploration. Thus this paper explores the ethical and legal arguments in favor of and against “therapeutic privilege” and how professional code of ethics relates to legal position in the Indian context where informed consent is legally mandatory. This paper employs reviewing existing literature and content analysis of few court judgments relating to therapeutic privilege and truth telling.

O-Examining the views of stakeholders in low-income settings on how public health research data should be shared.

Ketaki Hate, Sanna Meherally, Neena Shah More, Anuja Jayaraman, David Osrin

The idea of making data openly accessible germinated when the Human Genome Project, the world’s largest collaborative biomedical research project, adopted the Bermuda Principles mandating that research findings be made available on a publicly accessible platform. Arguments in favor of data sharing are that it will promote faster analysis of datasets by a community of researchers, lead to more efficient use of datasets with cost savings and improve the quality of analysis. Predictably, the movement for data sharing began in high-income countries, but considering the increasing amount and range of health research conducted in low-income countries a need arose for research to inform the development of effective, ethical and sustainable approaches to data sharing. Existing literature about data sharing comes from funding agencies and lacks opinions from stakeholders in low-income settings. We are collaborating in a multisite study led by the Ethox Centre, University of Oxford and funded by the Wellcome Trust. Data are being collected from five international sites: SNEHA, India, KEMRI-Wellcome Trust Research Programme, Kenya, University of KwaZulu-Natal, South Africa, Mahidol University, Bangkok and Wellcome Trust Major Overseas Programme Oxford University Clinical Research Unit, Viet Nam. The India site research aims to understand the views and roles of key local stakeholders in the research process on how ethical issues about data sharing are

perceived. The goal is also to inform the development of models for practice, including appropriate community engagement and consent processes, data sharing policies, and governance mechanisms. Methodology: The study is qualitative and data were collected from a range of people involved in research in varying capacities such as ethics committee members, policy managers, senior and junior researchers, field interviewers and community members. Sampling was purposive and flexible to account for a broad spectrum of respondents and to allow further data collection when new issues arise or gaps were identified. In-depth interviews were conducted with participants familiar with data sharing and focus group discussions with groups with limited familiarity. Interviews followed a semi-structured topic guide and hypothetical escalating scenarios designed to make respondents think through the implications of data sharing. All interviews were anonymized. A framework analysis developed in *NVivo* was used for coding and theme development. Analysis, line of inquiry and expected outcomes: Emerging concepts and themes appear to cover a range of ethical issues that include confidentiality, whether anonymity can be guaranteed, the implications of collecting and storing vast amounts of data and uncertainty regarding its future use, deliberation over data ownership rights, obligations of researchers towards participants whose data is being shared, the implications for trust, consent, commercialization of data and the ethical importance of the sustainability of secure databases. It is expected that the research will help develop appropriate governance mechanisms by informing the development of a data sharing policy for local institutions involved in public health research.

- ***Research Ethics -1: Venue –Main auditorium Mtg Room 2***

O-Minimizing the risk of coercion in healthcare research: Facilitating integrity of informed consent

Shyamala Nataraj, Swaminathan Krishnan

The informed consent of participants is an integral requirement in healthcare research. However, many individuals in Indian healthcare and community settings are restricted from making a voluntary decision about participation by a range of structural factors including age, gender, social status, and pressure from gatekeepers within families, communities, and institutions. These factors can lead individuals to participate even where they may not want to do so. A sense of being coerced into participation may in turn compromise the validity of data collected from them. In this paper we identify specific factors that exert a strong influence on voluntary decision making about research participation by community members as well as healthcare providers in India, and describe specific ways in which they can be empowered to minimize this influence and maintain integrity of informed consent. Research method: Data for this paper are drawn from data collected as part of ethnographic research on informed consent conducted between August 2007 and August 2008 in Tamil Nadu state. Sources include focus group discussions with women accessing antenatal/postpartum care at public hospitals in the project area, and with HIV/AIDS counsellors at these facilities and participant observations in community settings. Thematic analysis was used to interpret data. The main ethical dilemma was to guard against inadvertently coercing individuals to participate in research related to informed consent in healthcare practice. Results: Our findings confirm earlier evidence that the ability of women seeking maternal and child healthcare in public hospitals to make decisions about research participation included age and interventions by healthcare providers and/or family members. Younger women and women who were pregnant at the time of participation were

more vulnerable to coercion. Women cited the inability to act against the advice of healthcare providers and/or family members because of a desire to conform to social norms as well as because of fear of consequences in addition, we found that the decisions of healthcare providers about participation were also strongly influenced by a number of factors including instructions by superiors, respect for researchers, peer pressure, and fear of consequences of refusal. Steps taken to minimize the impact of potential coercion in participation included discussing reasons for participation, rescheduling FGDs to a later date, allowing participants to remain silent, providing assurances about absence of consequences in the event of non-participation, and seeking consent both before as well as at the end of the discussion. Implications: Respect for autonomy of an individual is a central tenet of the principlist framework of bioethics that has been widely adopted globally as well as in India. Informed consent is viewed a marker of individual autonomy, and is an essential requirement in healthcare research and practice. Voluntary decision-making is a fundamental requirement for an informed consent. Our findings are important because they identify a set of simple, yet specific steps that can help to minimize the influence of authority figures and empower individuals to make a voluntary decision and strengthen integrity of research.

O-Frequency and factors associated with honorary authorship in biomedical Indian journals

Akash Shah, Satish Rajasekharan, Anup Bhat, John Solomon

To our knowledge, honorary authorship in biomedical Indian journals has not been reported. We report the frequency and factors associated with honorary authorship in 18 biomedical Indian journals. We hope our paper increases the awareness of the ICMJE authorship guidelines and the general issue of honorary authorship among Indian researchers. Research methods: First authors of original research articles published in 9 Indian biomedical journals in different medical specialties with an impact factor rating, and 9 Indian biomedical journals (similar specialty to impact factor journal) without an impact factor between January 2012 and December 2013 were contacted for the study. An internet-based survey was administered and the reported prevalence of perceived, ICMJE-defined, and unperceived honorary authorship were measured. Multiple factors were extracted from the survey and analyzed to determine whether they were associated with these measures. Results: The response rate of the survey was 27% (245/906). The prevalence of perceived, ICMJE-defined, and unperceived honorary authorship were 20.9% (50/239), 60% (147/245) and 46.9% (115/245), respectively. Residing in India was associated with perceived honorary authorship in the multivariate analysis ($P=.028$). Confirming awareness of the ICMJE authorship guidelines was associated with ICMJE defined, and unperceived honorary authorship ($P=.018$ and $P=.006$, respectively). Implications: Our results suggest that honorary authorship does occur in a substantial number of original research articles published in Indian biomedical journals. The most common reason for perceiving the inclusion of an honorary author was that the senior member/ head of the department were automatically listed as an author (25.5%). Respondents from India were more likely to have perceived the inclusion of an honorary author than those from other countries. We also found that the adherence of journals to the ICMJE guidelines of authorship was extremely poor. Authors and journals must ensure better adherence to the guidelines laid by the ICMJE to possibly reduce the incidence of such practice. We hope our paper increases the awareness of the ICMJE authorship guidelines and the general issue of honorary authorship among Indian researchers.

O-Institutional Ethics Committees constitution and Compliance with recommended ethical guidelines in and around Mangalore- A Pilot Survey

Ann Thomas, Vina Vaswani

Research ethics committees play an important role in research participant protection and welfare. Advent of research ethics committee (EC) in India came into being more than 30 years back. Thereon many guidelines have been issued by Indian Council for Medical Research (ICMR). Guidelines included recommendations for standard operating procedures for ECs. However, in 2003 an ICMR-WHO survey indicated that many committees did not meet the regulatory requirements in terms of composition and function. Since then only a very few reports have been published on this subject. Hence, the purpose of this study was to assess the constitution and compliance of the institutional ethics committees (IEC) in and around Mangalore to the recommended ethical guidelines. Methods: A cross sectional study was conducted among the IECs academic health institutions (medical, dental, nursing, physiotherapy and pharmacy colleges) and hospitals in and around Mangalore city. A convenience sampling method was used and only one member either the chairman, deputy chairman or member secretary from every consenting IECs were invited to participate in the study. A pretested structured self administered questionnaire based on the ICMR-WHO survey questionnaire was the survey tool. The study was conducted for a period of two months and the data was subject to statistical analysis. Results: Out of the 22 IECs invited, 19 IECs participated in the study. 16 IECs were part of the academic health institution; two were private hospitals and one academic health university. The main findings of this study were the presence of head/member of the same institution as Chairperson (n=8, 42.1%), poor multidisciplinary and multi-sectorial representation of members (n=12, 63.2%), lack of periodic reconstitution (n=11, 57.9%), inclusion of subject expert in decision making (n=12, 63.2%), absence of periodic monitoring of the research proposal (n=9, 47.3%) and absence of archiving of documents(n=10,52.6%) in most of the IECs. These findings are contradictory to the ICMR guidelines. Majority felt EC review of research as important and the need for ethics training as essential for EC members and researchers. Conclusion: The findings of our survey suggest that the IECs are still grappling with issues regarding composition /structure and compliance with ICMR guidelines, thus compromising its independence/competence and the primary function of protection of the research participant. A concerted effort to strengthen the IECs through regulations and training in research ethics of members, potential members and researchers is the need of the hour to fulfill their stated mission.

O-Maintaining Uniformity in review by Ethics Committees: The importance of Accreditation

S. Swarnalakshmi, Anant Bhan, Prabha Desikan, Medha Joshi,

Research stakeholders depend on Ethics Committees (ECs) to oversee ethical aspects of research: this involves not only granting initial approval and providing ongoing monitoring of study conduct, but also ensuring that the highest ethical standards are maintained during the review and conduct of the project. The ECs' approval serves not just to meet regulatory requirements, but also to ensure the dynamic and continuing responsibility of promoting ethical conduct of research. ECs might differ in their way of operations, however the ultimate goal remains to protect the safety and welfare of study participants. Hence, uniformity in review procedures and functioning of ECs ensures that ECs function more efficiently for protecting human research participants. India has seen a lot of recent regulatory changes. It is now

mandatory for ethics committees reviewing regulatory clinical trials to register with the CDSCO. 880 ECs had registered with the CDSCO as on December 3, 2014. In July 2013, the Prof. Ranjit Roy Chaudhury Committee recommended that the ethics committee must be accredited. It further recommended that a Central Accreditation Council should be set up to oversee the accreditation. Methods: While India is yet to develop a standard model for accreditation of ECs, FERCAP-SIDCER and AAHRPP offer recognition and accreditation respectively and have recognized/accredited ECs in India. Eight ethics committees in India have obtained FERCAP SIDCER recognition while certain other hospitals in India have obtained AAHRPP accreditation. The presentation will enable EC members to understand what criteria are currently used for accreditation of ECs, focusing on the FERCAP-SIDCER criteria; and help EC members understand how an accreditation survey is conducted, prepare for survey, survey process, and be aware of the challenges involved. Some of the authors' institutions have gone through accreditation processes. Hence, details will be based on practical experience. Results: This presentation strives to analyze the accreditation and recognition mechanisms for ethics committees offered by FERCAP. This will help ECs which are interested in preparing for an accreditation/recognition survey. Implications: It is essential to address the problems faced by ethics committees in view of the structural constraints within which ECs operate. These include limited training in bioethics, inadequate administrative support, insufficient time for review due to heavy workload, space constraints, ambiguity regarding their roles and responsibilities, and limited scope for self-evaluation and assessment. Lack of infrastructure, manpower, funds and time can be a major hurdle for improving the quality of ethical review. This presentation will discuss the constraints and challenges for ECs striving to work towards standardization, recognition, and accreditation, help ECs prepare for an accreditation survey at the institutional level, discuss challenges and identify solutions and best practices.

- ***Public Health Ethics-1: Venue –Annexe 3 Mtg Room 1***

O-A Critique of Extractive Capitalism: The Role of Public Health Ethics

Angus Dawson

This talk focuses on a number of ethical issues that arise from the establishment of what Mohantry (2014) calls an 'extractive capitalist economy' in India and elsewhere in the world. The central feature of this brand of modern economic activity is the practice of large-scale mining of metal ores. The common justification of such activities is the need for development. However, 'development' in this context is interpreted in a particular way, where economic productivity (such as state domestic product) is held to be the relevant measure of progress. The mining companies are often foreign owned and are perceived as involved in corruption at state level. Such extractive industries often fail to deliver on their promises of employment and other economic benefits to the local population. They often involve significant costs, including environmental damage, destruction of long-standing communities and livelihoods, health impacts etc. The starting point for this critique is the articulation of a broader notion of development: one focused on the impact upon the integrity of communities, the environment and upon people's health. The resources of public health ethics are brought to bear upon these issues, and it is argued that relevant key concept such as equity, solidarity and the common good can be used to critique the focus on narrow economic modes of development. It is argued that the values of public health ethics can be used to argue in favor of a more harmonious idea of development,

one focused on providing community-based infrastructure and support as a means of providing for the enhancement of human flourishing and community health.

O-US-funded Measurements of Cervical Cancer Death Rates in India: Scientific and Ethical Concerns

Eric J Suba

Prior to 1990, rigorous scientific studies had established cervical screening to be an archetypal preventive health intervention. Nevertheless, starting in 1998, three separate randomized trials in India funded by the US National Cancer Institute (NCI) and the Bill & Melinda Gates Foundation have compared, in aggregate, cervical cancer death rates among 224,929 women offered cervical screening to cervical cancer death rates among 138,624 women offered no screening whatsoever. To date, at least 254 women in unscreened control groups have died from cervical cancer. Methods: Since 2002, scientific and ethical concerns about US-funded death-rate measurements were published in peer-reviewed journals and shared with leading scientists at international conferences. Summaries of published concerns were shared with the Gates Foundation in November 2009; with the US Presidential Commission for the Study of Bioethical Issues in January 2011; and with the US Office for Human Research Protections (OHRP) in May 2011. Because of recent disclosures that top US health leaders may have inappropriately interfered with US bioethical investigations, NCI Director Harold Varmus, Mr Bill Gates, and Ms Melinda Gates were invited to explain what was learned, that was not already known, from the deaths of Indian women in these US-funded studies. Predictably, nothing that was not already known was learned from US-funded death-rate measurements. Inexplicably, death-rate measurements among unscreened women were continued even after mortality benefit from screening had, predictably, been confirmed. US-funded death-rate measurements may have needlessly delayed development of indispensable, life-saving public health infrastructure. US-funded death-rate measurements proved to be scientifically irreproducible, yet are still being used to promote inappropriate global health policies. Peculiar statistical bias embedded in US-funded death-rate measurements yielded the absurd conclusion that Papanicolaou screening does not prevent cervical cancer, which launched a global marketing campaign for a proprietary human papillomavirus (HPV) screening test unaffordable to the women among whom death rates had been measured. The lack of equipoise embedded in the defective scientific design of these studies required inadequate informed consent. Outcome of Ethical Inquiry: In 2012, OHRP determined that the NCI-funded study was unethical because its subjects had not provided informed consent. OHRP has no authority to investigate the studies funded by the Gates Foundation. The 2012 OHRP determination contradicted previous assurances from top US health leaders. In 2013, top US health leaders dismissed the validity of the 2012 OHRP determination. Implications for Bioethics: High-quality cervical screening must be provided to all surviving unscreened women. Study victims should be promptly and fairly compensated. Editors of medical journals that published data from these studies should assess whether they have been compliant with international guidelines regarding human research protections. Problematic US-funded studies in India reflect systemic flaws in global health. Global health organizations should institutionalize a commitment to “improving health outcomes as rapidly as possible among as many people as possible,” and assimilate the policy implications of that commitment. However, because US leaders are not accountable to citizens in other countries, the status quo may not change.

O-Ethical considerations of Community Health Workers in Jharkhand

Suranjeen Prasad Pallipamula, Haldhar Mahto, Vandana Prasad, Ganapathy Murugan

At the community level, various health workers work together and carry the burden to deliver healthcare and allied services. These workers include the ASHA, Anganwari Worker and the ANM. It is evident that most of the preventive and promotive work is carried out by this workforce. The purpose of this study is to look at the ethical considerations these workers used to define their work and from where they drew them. Research method: Qualitative in-depth interviews are being conducted amongst ASHA, Anganwari Workers and ANMs in three blocks of Jharkhand. In order to triangulate the data – in-depth interviews with their supervisors and independent observers (like village level teachers, social workers) are also being conducted. The data will be analyzed manually. The Ethical issues that are being explored include the workers understanding of Justice and Equity, especially with relation to access to care and how they go about addressing perceived inequity and injustice; and the understanding of autonomy, the right for self-determination of individuals and community. Implications for bioethics: Community health workers form the bulk of the health workforce and are the bulwark. They usually are from the local community, and undergo short trainings to take up their tasks. Studies on their understating of ethical issues and how they address them are rare. The results of this study would provide us an understanding of their perceptions.

- ***Ethics of Care: Venue –Nursing College Mtg Room 1***

O-Ethical Dilemmas experienced by Clinical Psychology Trainee Therapists

Poornima Bhola, Ananya Sinha, Suruchi Sonkar, Ahalya Raguram

Ethical issues are often complex, multifaceted, and may not always have unambiguous answers. Practitioners may have differing interpretations of ethical codes depending on their cultural or sub-cultural context or their own personal values. In the absence of ‘absolutes’, ethical dilemmas are inevitable during the psychotherapeutic interactions. These complexities and challenges may be magnified during the training phase. This exploratory research looks at how trainee therapists perceive and experience ethical dilemmas in the therapy space. Methods: The sample included 35 M.Phil trainees and Phd Scholars at the Department of Clinical Psychology, NIMHANS, who provided written informed consent and completed the anonymous and confidential online survey. The online survey included five open-ended questions about any one ethical dilemma faced in the context of a psychotherapeutic interaction with a client. Participants were asked about the questions that emerged and concerns experienced, the process of resolution (if any) of the dilemma and the utility of professional ethical guidelines. Qualitative analysis was carried out using thematic content analysis of the responses. Results: The results highlighted salient ethical dilemmas centering on confidentiality, boundary issues and dual relationships. Client revelations about suicidal ideation and sexual abuse were some of the most ethically challenging issues. The results indicated both the difficulties in adequate resolution of dilemmas as well as the effective strategies used. Implications for bioethics: The findings have implications for enhancement of training in the ethical decision-making for psychotherapists and counsellors. The need to develop experiential and participative training methodologies, which go beyond the knowledge of professional ethical codes, will be discussed.

O-Ethical dilemmas in care of patients admitted to a palliative care unit in South India: A Qualitative Study

Catherin Nisha, Johnson AR

Hospice and palliative care is well recognized as the ideal model of care for the terminally ill. However, ethical issues are frequently encountered during the provision of palliative care. Data on ethical dilemmas faced by health care providers in palliative care settings in developing countries is scarce. Objectives: To identify ethical dilemmas in the care of patients admitted in a palliative care unit in South India and factors related to these ethical dilemmas. Methods: Qualitative data was collected by in-depth interviews of all the nurses involved in the care of terminally ill patients in a palliative care unit in rural Kerala from November 2013 to July 2014. The data was interpreted, coded and grouped into key domains before analysis. Results: A total of seven in-depth interviews were conducted, which revealed a number of ethical dilemmas and challenges that the nurses encountered while providing palliative care. It was noted that patients' preferences and decisions were influenced by family members. Dilemmas were not faced while taking decisions regarding hydration and nutrition. There were ethical dilemmas with regards to the place of care, alternative treatment and therapeutic strategy. Nurses felt that the referral of patients for further management was hindered by financial constraints. These ethical dilemmas left the nurses confused as to how ethical their actions were. Conclusion: This study identified ethical dilemmas with regards to place of care, alternative treatment and therapeutic strategy. Ethical issues in palliative care settings need to be addressed, with a possible role of institutional ethics committees to help in decision-making. Training in ethics for health professionals would assist in solving the ethical dilemmas in palliative care.

O-To Care or Cure? Responding to drug resistant TB (M/XDR-TB) and the role for palliative care.

Joseph M Sawyer

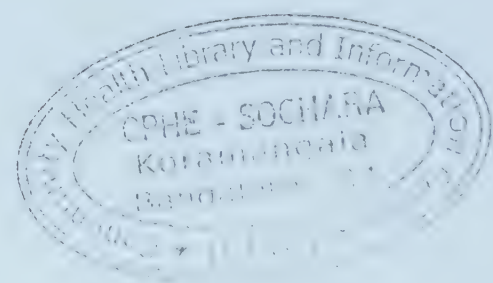
As healthcare evolves to become a sought after commodity in the west, issues around care and compassion seem to be increasingly neglected. Using Multidrug Resistant Tuberculosis (MDR-TB) as an example of a potentially terminal disease, I aim to look at our approach to care in life threatening conditions and our moral and ethical obligations to help relieve suffering through holistic mechanisms. The control and treatment of MDR-TB represents one of the most significant challenges to global health in recent times. In addition to public health concerns, there is an enormous burden of suffering on the patient and their families. Despite guidance on improving treatment outcomes, there is little focus on how to support individuals in their suffering. Palliative care offers a potential framework to support patients within the physical, psychosocial and spiritual domains of suffering and has been proposed as necessary component in the global strategy to fight TB. The purpose of the study is to describe patient's perceptions on the burden of drug resistant tuberculosis and explore the role of palliative care in alleviating their suffering. Research method: In-depth ethnographic research was conducted over a month long period. This combined four in-depth interviews with patients suffering from MDR-TB as well as informal interactions and non-participant observations across a range of palliative care and TB treatment providers. Results: Patients were found to suffer profoundly beyond the physical realms of disease. Suffering was present from the point of diagnosis and stemmed from prognostic uncertainty, vulnerability in disclosure of disease status and a dichotomous relationship with drug therapy. Coping mechanisms ranged from informal counseling to community support and spiritual engagement. Psychosocial, physical and spiritual domains of

care were often interdependent both in terms of their results, but also in the way that they were provided. This concept refers to the provision of 'holistic care', which was of great importance to individuals. Implications for bioethics: Patients suffer with problems that extend beyond the capacity of current TB treatment programs. The palliative care paradigm provides an alternative that would seemingly accommodate for MDR-TB patients needs. Specifically, the delivery of psychological, social and spiritual support around issues of prognosis, disease disclosure and treatment adherence are of vital importance. The role for palliative care in MDR-TB provides fresh insights into the relationship between individual and population health based on theories of care ethics. Discussion within this framework leads us to the question of whether palliative care is a human right and should be an essential component of health care.

O-Isn't Integrity in Medical Practice a Utopian Dream in the Society of Today?

Thomas Alexander

Integrity is a trait that cannot be selectively applied in Medical Practice – it has to be a part and parcel of one's character. Since character development occurs very early in life, efforts should be made to incorporate the core value of integrity, much before youngsters attend medical college. Discussion: Integrity as a virtue has to be inculcated from a very young age. Primarily this will occur at home in the preschool period and continue during the early school period. Character development generally has a pyramidal shape, with the maximum changes occurring at a young age and incrementally decreasing till adulthood. Certainly life-changing experiences do occur later on in some individuals, causing a total change in their worldview of morality, but these instances are uncommon and unpredictable. Hence society has to ensure that proper moral development begins early. Since no specific action can be taken to ensure this in the homes of the preschool child, the earliest institutional setting where a child can be exposed to character development is in school. The 'moral science' periods in schools of yesteryear have vanished. Sometime should be allotted in the school curriculum for character development. With the mad rush of competition for marks alone, exposures to ethical values in life are no longer imbibed by school students. Naturally, unless there is a strong emphasis on this in their home, such virtues are perceived as unnecessary by young college students, including medical students. They generally regard sessions on bioethics as a waste of time, since character building is not one of the goals of the vast majority of students. Furthermore a very large proportion of students attempt to learn only whatever is likely to be assessed at examinations and since morality and ethics are not examined, sessions on these are generally ignored. Exposure to areas of character development during medical college days will have much greater impact if these are reinforced rather than introduced for the first time at college level. Therefore dedicated time for moral development is essential in schools and this should be followed up during college education, including professional colleges. If this is not implemented the effort to yield ratio of programs aimed at character development in medical colleges would be dismal.



MP-120
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- *Ethics and Reproductive Health: Venue –Nursing College Mtg Room 2*

O-Dying to Give Birth: The Case of Yuma Sherpa and the Unethical Medical Terrain of Assisted Reproductive Technologies

Sarojini NB

On January 30, 2014, 26 year old Yuma Sherpa died while trying to give birth to someone else's dream. Unable to gain consciousness after her egg extraction process, she died away from home in an alien hospital bed. Promised rupees 25000 for 'donating' her eggs for a surrogacy process by a posh South Delhi infertility clinic, Yuma is not a rare case. Medical negligence spurred by the unregulated and unethical medical practices that form part of the reproductive tourism industry of which egg donation and commercial gestational surrogacy are a very big part have been most wrought on the bodies of women undergoing these procedures. The harmful effects of egg harvesting through OHSS and invasive egg extraction on women's bodies have been discussed and debated on—but to very little impact in the practice and spread of infertility treatment. SAMA's report on ARTs (2011) and commercial surrogacy (2012) has found the rampant practice of unethical medical procedures especially on the bodies of women participating in invasive procedures in exchange for compensation. The practice of giving and supervising treatment in such cases is seen to be governed by considerations other than the protection of her life. Is this because most women who volunteer, are coaxed or coerced into egg donation and gestational surrogacy belong to economically weaker and marginal sections of society? Is their life measured as comparatively of less value in an arrangement driven by the considerations of a neoliberal market that privileges technological innovations over human lives? Clinical practice in India in the area of infertility is creating possibilities that have a direct and deep impact on women's bodies. Drawing from the extensive fieldwork on ARTs and surrogacy practices in India, this paper positions these clinical practices within the larger frame of reproductive tourism and the commercialization of body material. What does the Yuma Sherpa case mean for the practice and proliferation of reproductive tourism? What role does regulation play in paving the way for ethical medical practices especially in relation to women's bodies and health rights? How can commercial arrangements involving the sale and rendering of reproductive services be more equitable in terms of medical practices? This paper pays tribute to many such women who have given up their lives for their families and for the possibility of other families. The paper seeks to bring to light the ways in which the reproductive tourism industry is exploiting the desire for a biological child by creating a demand and supplying reproductive bodies and bodily services.

O-Ethical Imperatives: Bodily integrity in the case of Surrogates ***Deepa Venkatachalam, Sama Resource Group for Women and Health***

What are the ethical imperatives when we center-stage bodily integrity in a conversation on medical practice, especially in relation to 'risk' and 'informed consent' in surrogacy. What form does the exchange between the doctor and the surrogate take given a) enough research into the long term health risks of ARTs for mother and child has not been undertaken, and b) a contract is being signed between parties with huge power inequities. What form should such an exchange take instead? And what does this tell us about the relationship of bioethics to justice? Can and should bioethics only be about ticking four boxes within the four walls of a clinic setting? Is it not always already implicated in issues arising from the nexus between science, patriarchy and market, especially in the case of something as supply-driven as ARTs and surrogacy? When we

talk about ‘upholding patients trust’ (another sub theme), can we imagine the surrogate as a patient too? Or is she disqualified from this category because she is not paying for the procedures she is undergoing (she pays physically and psychologically of course, even if she does not pay financially)? There are larger parallels with unregulated private medical practice in general, but we also see instances of conflict of interest in a) the intermingling of ART use and stem cell research b) the pressures from the social parents (the ‘paying’ party) versus the interests of the surrogate (be it multiple embryo transfer, c section, ovarian hyper-stimulation etc).

- **Corruption in Health Care and Research: Venue –Nursing College Mtg Room 3**

O-Corruption in the practices of Central Drugs Standard Control Organization (CDSCO): findings from 59th Parliamentary Standing Committee Report on Functioning of CDSCO (May 2012)

Sarojini N, Vaibhao, Sama-Resource Group for Women and Health

The corruption in public health occurs at various levels and through various mechanisms. One of the ignored areas for scrutiny in the past has been the regulatory offices themselves trusted to curb corruption. The report “Functioning of the Central Drugs Standard Control Organization (CDSCO)” was presented in the Rajya Sabha and laid on the table of Lok Sabha on May 8th, 2012. The report indicates severe lapses in the functioning of the CDSCO and nexus with industry in approving drugs without trials. The discussion section presents salient findings of the report which indicate need for examination of similar regulatory bodies. Discussion: The inherent flaw was noted even in the mission statement of CDSCO which was to serve the aspirations of the pharmaceutical industry. The systemic issues such as understaffing and under qualified human resource were also highlighted; however, the findings about nexus with pharmaceutical industry, medical practitioners for approval for marketing of drugs without clinical trials in the country indicated widespread corruption in the regulation of the clinical trials and conduct of medical practitioners. CDSCO has approved 2167 new drug during 2001-2010. From randomly chosen 42 drug approvals for scrutiny, a less than 2% sample of all approvals; CDSCO office could not provide any document on 3 controversial drugs discontinued in other countries. In case of other drug out of those 42 drugs, serious issues such as approval without phase 3 trials, trials on fewer participants than recommended, fewer sites than recommended, approval to drugs banned in most developed countries, approval of drugs not relevant to India, and non consultation with medical experts were found. During 2008-10, 31 drugs were approved in India without conducting any trials on Indian patients. The post marketing surveillance data was also not available for a random sample of these approvals. The report also clearly showed involvement of pharmaceutical industry in the process of recommendations sent by the medical experts to approve the drugs without clinical trials in the country. The committee concluded that the medical practitioners have violated the code of ethics specified by Medical Council of India. The committee stated that CDSCO had grossly violated the law of the land through their approvals. The state drug authorities also gave approvals to large number of Fixed Dose Combinations without prior approval of CDSCO. There has been very little action taken on these finding by government. It was decided to constitute another committee, which will further investigate the matter. This indicates an attempt to ignore the recommendations of the 59th committee report and delay the urgent actions required.

O-Views of Medical Students on Corruption – Lessons from the field

Thomas M. Walter, Sweety Nirmala, S Merish, M Tamizhamuthu.

Tackling corruption in the health sector is essential for achieving better health outcomes. Corruption can have severe consequences on access, quality, equity and effectiveness of health care services. Corruption in the health sector can be a matter of life and death, especially for poor people in developing countries. Systematic analysis of vulnerabilities to corruption is necessary to identify problems, select priorities, and sequence interventions in a sector-wide approach. This study is an effort to understand the ideas and ideals of Medical Students who are Future Physicians and Policy Makers regarding corruption in Health care and their suggestions to effectively tackle it. Research Method: Two Siddha Medical Colleges were selected for the survey, one being a Government college, and another Private Medical College run by Traditional Practitioners' Trust. Around 200 U.G. students participated in the survey and the study results are being discussed in detail. The survey questions include concepts such as the students view on the definition of corruption, causative factors, Impact of corruption in the health sector and their idea/observation about the morbidity and mortality incurred due to corruption. Issues such as doctors actually committing crimes - manipulating medical reports in medico-legal cases, providing false certificates for financial gains, sexually assaulting their patients, and even trading in human organs were also asked for their opinions. They were also asked the ways of dealing people who were caught in corruption, suggested ways to uphold professional Ethics and Honesty etc. In the Policies sector, the idea of the Medical students regarding forming IHS (Indian Health Services) equal to that of IAS, to run our own healthcare system were also asked. Their view regarding inefficiency and greed as equivalents to corruption was also recorded. Results and Discussion: The results were thoroughly analyzed and tabulated category wise. The students' reflection regarding effects of corruption, level of corruption among healthcare professionals, lack of enforcement of Healthcare regulations and the suggested remedial measures are also discussed in detail. Apart from these findings the areas where Students of Government and Private Medical Colleges contradict regarding corruption are also identified and documented. The questionnaire results clearly indicate the idea of the current medical students regarding corruption and upholding professional Ethics.

O-Ethics deficit health care institutions – An ethical analysis of the institutional behavior based on the selected case studies

Abhijit Das, Edward Premdas Pinto

The integrity and ethics in health care include not only the relationship and transaction between the individual patient and the provider but encompasses also the character and culture of the health care institution. An institutional culture shaped by the lack of ethics results in gross violations of the dignity of the vulnerable. With this hypothesis a study was undertaken in Madhya Pradesh (India) to understand the impact of such ethics-deficit health care institutions on the lives of the most vulnerable such as women seeking health care during the critical hours before delivery, children of vulnerable and Dalit communities seeking nutrition in the anganwadis. The purpose was to analyse the experiences of the most vulnerable from across the districts seeking critical maternal health care or nutrition from the perspectives of ethics and accountability. Research method: The approach to this enquiry was qualitative and was based on case study narratives written up based on individual interviews. These individuals were identified by the community based on the social memory of those who have gone through grave difficulty or suffering in the recent past. The districts and villages were the

field intervention areas of the civil society organization who were part of the enquiry. This resulted shortlisting of about forty two case studies. They were analyzed using the qualitative approach and the framework of ethics and human right to health. Results: The narratives were organized under different themes for analysis: maternal deaths (4), infant deaths (5), systemic denial of maternal protection incentive (JSY), demand for informal payment and experience of callousness in the health care providers (8), stories on discrimination faced by dalit women in accessing maternal health services (10), and stories of denial and discrimination faced by Dalit women in anganwadis during pregnancy or in accessing nutrition for their children(15). A very strong societal prejudice based on caste and status is perceived by community as the institutionalized culture as happening over a long period of time and experienced through verbal abuse. The cases of maternal deaths and some cases of infant deaths were preventable with timely care. Stories of discrimination and denial of services were also alluded to the culture of callousness and unaccountability to the community of the vulnerable as a whole. The health providers, on the other hand, instead of being empathetic to deaths and sufferers, were defiant and arrogant busy with victim blaming and defending their colleagues and institutions. In not even a single case, any victim was heard or the grievance was addressed. Implications for bioethics: The analysis of the case studies from the ethical framework indicates that the health care institutions are characterized by the social and cultural prejudices. Such behaviors tend to give rise to institutional culture of non-accountability and sense of impunity among the health care providers placed already in a skewed power relationship with the community and the vulnerable patients. Negligence and disrespect to human dignity of the most vulnerable indicates the degeneration of integrity in health care institutions. Such impunity and perpetuation of unaccountability either to professional conduct or to ethical behavior has resulted in the ethics deficit institutional culture. On the other hand such culture promotes further the unaccountability of the health care professionals. The autonomy of the vulnerable women gets utterly compromised as they have no other option but to choose between a public health provider or no care and the principle of beneficence upholding the good of the patient are totally compromised. Such mindset shaping institutions result in serious physical and emotional harm to the most vulnerable. In addition, the processes of justice or fairness are not available to any one of them. This points to the need of taking the discourse of bio-ethics beyond the individual realm of patient and provider into the processes of institutionalized culture of the lack of respect for ethics, processes of accountability and the spirit of human rights to the institutional behavior which condones, tolerates and legitimizes such behaviors. This calls for the shaping and molding institutional culture of ethics and professional integrity not only through persuasive individual behaviors but also by setting up protocols which will promote such institutional culture of ethics and integrity.

O-Corruption in public health systems: an overview (ethical perspective)

Manivelan Rajamanickam, Tmt. Kalaivani

The provision of health and health care in India is partly done by the respective state governments and central government in the form of various schemes intended to benefit the common man. The unregulated private sector occupies the center stage of health care provision to the people even though its modus operandi is totally opaque. People are forced to spend from their pockets (out of pocket expenditure) due to lack of sound health policies by different state (provincial) governments and the Central Government. The schemes which are implemented by the governments really brought into operation with the good intention of

reducing the health inequalities and striving to achieve the MDG goals. The provision of health care to the common man including women, children, tribal, SC/ST and other vulnerable groups is not at the expected and desired level due to siphoning of funds earmarked for the health programs at various levels. After the introduction of NRHM (now NHM) the position of the people of India in terms of quality care, access, affordability of health care provision has increased substantially with the hope for further improvement in order to attain the full Universal Health Coverage (UHC). The hierarchy at the various Public Health Systems (Bureaucracy, Medical and Para -medical cadre) and indifferent attitude and other actions resulted in the sub optimal utilization of scarce resources earmarked for Health. The barely less than 1% of GDP on health spending is plagued by system inefficiencies and corrupt practices. The apathy on the part of political leaders, executives and bureaucracies resulted in the poor implementation of health schemes which needs closer introspection and serious thinking in order to achieve MDG goals and the Universal Health Coverage in India in the coming years. The various audit enquiries and paper news items (reports) are clearly pointing towards the rampant corruption at all levels with scant respect for the ethical values in the provision of health care services to the people. India is a land known for its cultural values and heritage in day to day activities like ethical manner in conduct of business including rolling out of welfare schemes. Article 21, encompasses the Right to life including right to clean environment and other facets of dignified life of an individual. Here the common man entitles to a just and equitable distribution of resources meant for its noble cause. Is it ethically correct to turn a blind eye to the happenings at various levels of health program implementation? Is there a way out at all to bring in ethical integrity on the part of all stakeholders in the implementation of various health schemes?

- **Workshops: Day 1: 11th December, 2014; 2:00 to 4:00 pm**

WS-The balancing act of caring: boundaries in healthcare practice

Venue: Main Auditorium Meeting Room 1

In recent times, news items abound with reports of sexual boundary transgression by people in positions of trust and power. The health professional is not immune to similar concerns. The integrity of the health professional depends on whether boundaries are crossed. This is more so, in relations to sexual boundary violation. The responsibility lies with the health professional to maintain healthy boundaries.

In the health professional – patient relationship, boundaries mark the ‘edge’ of appropriate professional contact, the “line” that is drawn to help define roles & interactions. Establishing safe, reliable and useful boundaries is one of the fundamental responsibilities of health professionals. Many authors distinguish between boundary crossings (which do not cause harm) and boundary violations, (which do). Boundary issues in clinical practice have no black and white answers. Choices about whether to cross boundaries confront us daily.

The goals of the workshop are

1. To explore what is a boundary.
2. To define, describe and illustrate a range of boundary issues in health care practice.
3. To understand the differences between boundary crossings & violations.
4. To understand the harm done by boundary violations.
5. To learn how to prevent and deal with boundary crossings/violations in practice.

In this workshop boundary issues will be addressed through games, role plays and case vignettes in addition to presentations.

At the end of the workshop, the health professional will be able to appreciate the concepts of boundaries. They will understand the importance of boundaries in health care provider and patient relationship. The workshop will help them recognize potential pitfalls and learn how to prevent boundary crossings and violations.

Faculty:

Dr. Tanya Machado, Professor of Clinical Psychology, St. John's Medical College Hospital. She has extensive experience in general hospital setting. She has conducted similar workshops for different categories of health care professionals including Psychiatrists, Clinical Psychologists, Social Workers.

Dr. Vidya Sathyanarayanan, Associate Professor of Clinical Psychology, St. John's Medical College Hospital. She has worked in the Consultation Liaison Clinical Psychology setting for approximately 15 years. She is a member of the Organ Transplant Ethics Committee at St. John's Medical College Hospital.

WS-Professional and civil society perspectives on challenges and approaches in ethical practice of occupational health in India

Venue: Main Auditorium Meeting Room 2

Occupational health is a subject of neglect in India, especially in the context of over 90% of the workforce engaged in the informal sector. While risks are associated with each occupation, there are some such as manual scavenging (which is constitutionally banned) which are extremely precarious and undermine human dignity. Millions of workers in the mining, construction and service sectors are exposed routinely to silica or asbestos which lead to lung diseases and premature mortality, to the extent of reducing life expectancy among the workers to 45 years. The onus is on the employer to ensure safety of workers, for which there are several regulations and guidelines. From an epidemiological and medical perspective, data on occupational diseases remains scarce. There are major gaps in routine practice, including the organizing of basic occupational health services, diagnosis and management of these conditions, and in the notification/reporting of identified cases. Some institutions are making efforts towards improving occupational health and safety. However, an ethical enquiry may help identify pressing issues that need to be addressed, and build greater knowledge among participants about challenges and potential solutions to addresses occupational health challenges, and the ethical basis of these challenges and solutions.

Process: A facilitated ethical enquiry through sharing of experiences of occupational health physicians and civil society resource persons will be organized. Each speaker will present their experiences in ten minutes, and the session will be completed in one hour. Specific issues that will be addressed include:

- Workers perspectives of occupational safety in the context of stone quarry and mining in MP and Gujarat - **Mr. Amulya Nidhi**

- Issues of diagnosis and compensation in the context of occupational diseases in Gujarat - **Mr. Jagdish Patel**
- Experience as an OH physician with tea plantations - **Dr. Bobby Joseph**
- Social Compliance Standards - **Dr. Bobby Joseph**
- Ethics frameworks in occupational health - **Dr. Naveen R**

The members of the audience (whom we hope will consist of occupational health professionals, young medical professionals, and health workers) will then be encouraged to contribute their experiences, concerns and approaches used in addressing these problems. Through the workshop, key issues will be summarized/ listed, based on which a statement of concerns and recommendations will be prepared and submitted to the Ministry of Labor and IAOH.

Expected outcomes:

- The participants will have an improved appreciation of the challenges and solutions in occupational health practice in India from the ethics perspective. This includes legal and other supportive aspects.
- There will be increased clarity both among the professionals and civil society groups working in this field about the challenges faced by each other, and how mutually supportive solutions can emerge.

The ethical enquiry will be strengthened due to inputs from audience members, and put together in the form of a report to be shared with the Ministry of Labor, Ministry of Health, Indian Association of Occupational Health, Labor Institutes, Universities, NGOS working with labor rights, Trade Unions, National Safety Council, NIOH, ILO,WHO and other National and International bodies.

List of facilitators:

- **Mr. Jagdish Patel** (Peoples Research and Training Centre, Vadodara, Gujarat)
- **Dr. Bobby Joseph** (St. John's Medical College, Bangalore)
- **Dr. Naveen R** (St. John's Medical College, Bangalore)
- **Mr. Amulya Nidhi** (Naishuruwat ,Silicosis Peedit Sangh Madhya Pradesh)
- **Dr. Adithya Pradyumna** (SOCHARA, Bangalore – logistics and rapporteur)

WS-Research on stored biological samples and medical records- Ethical issues and the role of IECs

Venue: Annexe 3, Meeting Room 1

More and more research is being done on stored blood or tissue samples and / or on archived medical records. The source of the biological samples is sometimes the pathology or microbiology labs where diagnostic investigations are done or the storage facilities of the institution where surplus blood samples and other samples are stored post a clinical trial or other research studies. The research interests with these stored samples vary from the testing and validation of a diagnostic procedure to the understanding of the cellular and molecular basis of diseases, identifying biological markers to predict disease patterns and in the development of new therapies. Medical, genealogical and lifestyle related data are also used either as linked to the stored samples or as a “retrospective” study to understand disease patterns, treatment patterns and so on.

There are ambiguities and lacunae in the present regulations that leave ethics committees and researchers with the following uncertainties:

- Whether there are human participants involved in such studies and hence whether ethical approval is required or not?
- Whether there are any risks at all to the individuals whose “waste” samples or archived medical records are used for research?
- In a stored repository, who owns the samples and data? Who makes decisions on their use/ misuse? Who is responsible?
- Is IEC’s ethical approval mandatory / desirable for such research?
- Is Informed Consent required for such research? Is it feasible? Are there are other kinds/ methods of consent possible?
- Can an institution / lab / bio-repository transfer or sell samples or data in its possession to another institution wishing to do research on them? Are there rules / guidelines / policies/ ethical norms determining the same?

Objectives

- This workshop will be primarily for IEC members and investigators as well, to understand the ethics of research on stored samples
- The workshop will look at how different IECs across India and internationally view and review research on stored samples and archived data.
- The workshop will evolve a consensus statement and a list of SOPs for IECs to address the ethics of stored samples and in the context of the existing lacunae in regulations.

Expected Outcome :

Clarity on whether ethical approval is required or not for research with stored samples and stored data and a consensus statement on the ethical issues involved.

A list of SOPs on reviewing the various ethical issues concerning ownership, transfers, commercialization, public/ patient involvement issues from consent to confidentiality to sharing findings to benefit sharing.

Facilitators:

- **Dr. Sanjay Pai**, Pathologist Columbia Asia, Bangalore, IEC member on a number of committees & Editorial board member, Indian Journal of Medical Research;
- **Dr. T.S. Sridhar**, Head, Division of Molecular Medicine, St. John’s Research Institute;
- **Ms. Manjulika Vaz**, IEC Member SJNAHS & PhD scholar in research ethics in biobanking.

WS-Preventing over diagnosis: Targeting the drivers and harms of too much medicine

Venue: Nursing College Meeting Room 1

To introduce the concept of over-diagnosis, and discuss the benefits and harms of newer disease definitions, treatments, and technologies, to enable effective clinical decisions.

Process: Globally, the medical community is rising up to the problem of over-diagnosis and overtreatment that may place patients at harm, and increase healthcare costs. In this symposium, the concept of over-diagnosis will be explained to help doctors identify the drivers of over-diagnosis. Emerging evidence from the BMJ’s *Too Much Medicine* campaign will be shared to

highlight the threat posed to human health by a growing medical culture of over-diagnosis. Through case studies, participants will explore newer screening and treatment guidelines that wrongly label patients as having a disease and subject them to unnecessary care. Participants will discuss in small groups instances where they may have witnessed elements of over-diagnosis and overtreatment, ensuing harms, and possible solutions. Through a participatory discussion, the following points will be highlighted:

- Methods to measure and report the problem of over-diagnosis
- Influencers that drive over-diagnosis including the effect of marketing, economic incentives, and guidelines
- Strategies to ensure appropriate translation of evidence into screening and treatment guidelines, and into clinical practice
- Initiatives across the globe to check over-diagnosis and overtreatment

Details of The BMJ campaign against corruption in medicine will be shared. This has stirred considerable discussion among doctors globally who have offered their support to restore professionalism and ethics in medicine. The BMJ patient partnership initiative will be discussed for possible solutions it offers to involve patients in decisions regarding their care.

Facilitator: **Dr. Anita Jain**, Indian Editor, *The BMJ*

WS-“Watching Bioethics”

Venue: Cafeteria-meeting Room

Objectives:

- To describe our venturing into film making
- To explore the different approaches that can be utilized while using videos as a teaching tool
- To discuss the variety of themes in which bioethics videos can be used effectively for highlighting bioethical issues

Description:

Bioethics discourse can be initiated in many effective ways. One of the most powerful ways of initiating such a discourse is through films that depict bioethical issues. At the Centre of Biomedical Ethics and Culture, Karachi Pakistan, we have been using videos including feature films, documentaries and docudramas as effective teaching tools for a variety of participants, ranging from high school students to masters level students. CBEC has also had some experience in producing its own purpose made teaching videos and we have so far produced 7 such films using very limited resources.

After the brief introduction, the first talk will describe our experience at CBEC and how we have come up with relevant themes for such videos. The speaker will describe how themes are explored by the group and scripts developed. The speaker will describe how we have made use of what we have, in the shape of manpower, turning physicians and medical students turned into amateur actors and how we improvise on sets and props, weaving the productions into our regular work commitments.

We have used these videos for teaching purposes in a variety of different ways including stand-alone sessions, coupled with role play, with lectures, in short segments with pauses and intervening discussions and so on, and have found different modalities suit different types of

videos. We believe our experience with such amateur productions is replicable in similar resource poor situations, and will be of benefit to our workshop participants. This talk will be followed by viewing of one of the films and we shall initiate a discussion with the participants of the workshop, to demonstrate how we use the videos to raise different aspects of the issue being discussed. The only true professional in our team has been our director, who often also doubles as a light and sound man, propos man, cameraman and on occasion also as a stand in actor when one of the actors freezes up. We will share his experience in dealing with amateur “actors” and more importantly, irrepressible “directors” who constantly encroach upon his domain. This experience will be useful for the workshop participants also.

In the next segment, we will then invite the audience to share themes that they consider relevant for developing into similar short videos. We will choose one suggested theme, and then work on developing a storyline and a theme based on the idea. This can be the seeds for a subsequent production. Substantial audience participation will be required for this to be meaningful and we will make sure there is general participation. This will be followed by a brief summing up of the session.

It is hoped that this workshop will stimulate others to also initiate video productions and increase the availability of this resource from this region. This could even lead to the formation of a virtual group which could collaborate in developing themes, storylines and scripts for videos that could be produced anywhere.

Facilitators:

- **Aamir Jafarey** Center for Biomedical ethics and Culture, Sindh Institute of Urology and Transplantation
- **Bushra Shirazi** Professor, Surgery, Ziauddin university, Pakistan

Abstracts Day 2: 12th December, 2014,

Oral Papers: 11:30 am to 1:00 pm

- *Research Ethics-2 Venue; Main auditorium Meeting Room 1*

O-Knowledge, Attitude and Practice of researchers about research ethics and laws on clinical trials in a tertiary medical college

Suparna Kanti Pal, Shyam Sharma

An offline survey was conducted on postgraduates and faculty members of a tertiary medical college in India to assess the knowledge, attitude and practice of researchers about clinical trials. Objectives: To know the level of knowledge, attitude and actual practice of post graduate students and faculty about Ethics & Law in clinical research. Research methods: A survey was done with a self-administered questionnaire in English in a post graduate teaching department in a tertiary Medical College in Urban India. Consent was taken from all the participants in the study stating the objective and methodology of the study and that the results would be published anonymously. It was also informed that some identifying data regarding designation, years of research experience would be made available in the publication. Results: 41 potential subjects were asked for consent. Two refused. 39 were included in the study. There were 31 post graduate students and 8 faculty members. Out of them 28 had either done at least one clinical study or at present doing one. 15 of them had either published a paper in a peer reviewed journal or have presented a paper/poster in an academic body conference. 9 of them had undergone a research methodology course including GCP certification. Three of them were also PI or Co-PI in a sponsored trial. All faculties and those students who participated in research methodology course were aware of major regulations in bio-medical research (Nuremberg Code, Declaration of Helsinki, and ICMR Guidelines for bio-medical research). Out of other 30 only 16 could identify the salient points of all the codes. Everybody stated that all the regulations are necessary for proper conduct of a trial. 20 of the 39 however commented that it was impractical to take informed consent in such a detailed manner. None of them had attended a research methodology course. Only 10 out of 39 were aware of the audio-visual recording notification of DGCI. Out of these 10, 9 have had attended research methodology courses. Out of the 39 participants all noted that they personally know more than one person, outside the list of study participant who has been involved in unethical conduct of clinical trial which include inadequate explanation of informed consent document, forging of number of study participants, data adjusting and accepting or offering guest authorship. Implications for bioethics: While the information about ethical regulations were known to all the participants, the detailed ones were known only to those who are actively involved in clinical research and those who have had a research methodology course. The attitude towards the informed consent was that of a regulatory compulsion in most people. Research methodology course was a significant factor in better attitude and knowledge. Unethical conduct among the researchers, are likely to be a cause for concern in India.

O-The legal rights-based considerations in cervical vaccine trials in India

Kelly A Dhru

The deaths caused during cervical vaccine trials in India raise burning questions about the nature of informed consent, and the legal rights of the participants of these trials, particularly in countries with a large amount of socio-economically vulnerable population. In light of these

debates and the recent cases in the Supreme Court, this paper asks, 1) how should the Indian legal system respond to the challenges raised by the deaths caused due to clinical trials, and 2) how do these developments inform the theoretical framework of legal rights? The theories of legal rights have been traditionally divided into: the Will Theory of Rights, and the Interest Theory of Rights, and there has been an inconclusive debate between these two families of theories since the Middle Ages. While the Will Theory of Rights focuses on individual autonomy and rational agency, the Interest Theory of Rights focuses on welfare-based considerations. In light of these theories, I will argue that the cervical vaccine trials in India highlight the shortcomings of a Will Theory based approach to understanding informed consent and legal rights of the participants, and that an Interest Theory based approach is required, particularly in light of the vulnerable populations. This paper will then explore a more robust framework of informed consent and the legal rights of the participants, which is based on the Interest Theory of Legal Rights and focuses on the welfare considerations. Research method: The legal and moral rights theoretical discussion in this paper follows the methodology of conceptual analysis, and the legal dimensions of the framework will be based on analysis and interpretation of regulations and case-laws of the Common Law countries.

O-Embryos: Humans or Biomaterials? Ethics and Law in Human Embryonic Stem Cell Research

J. Charles Davis

In the context of human embryonic stem cell research, in which human embryos are being used as biomaterials and are destroyed in the process of obtaining stem cells: the paper first discusses the ontological as well as moral status of the human embryo, raising questions, such as, when does an individual human being begin to exist? What is the moral status of an embryo? etc.; secondly, the views of major religions on moral status of the human embryo and their positions on embryonic stem cell research are presented; thirdly, the paper speaks on human embryonic stem cell research in India, where it is booming without any binding legislation and finally, it proposes legislative statements based on humans as humans without relying on external criteria. The new term “pre-embryo” sprang up in the mid-eighties of the 20th century literally meaning that pre-embryo is “a creature that precedes the embryo and is not an embryo itself.” Many argued that pre-embryos are not individuals until there are implanted into the uterus or until the primitive streak takes place, and thus it would be ethically permissible to use the IVF surplus embryos up to this stage for research purposes to produce stem cells.

Stem cells are unspecialized or undifferentiated cells which are not yet assigned to specific tasks and can thus in principle give rise to many different specific cell tissue types such as skin, liver, kidney, heart, etc. There are generally two types of stem cells: embryonic stem cells and adult stem cells such as nerve or bone marrow stem cells. A fertilized egg can divide into cells of all types inclusive of forming of an embryo. A fertilized egg cell is thus totipotent. Embryonic stem cells, which are taken from the inner cell mass of an embryo, are pluripotent, since they can grow into all cell types of the body except forming an embryo. Adult stem cells (e.g. nerve, bone-marrow stem cells) compared to embryonic stem cells are multipotent, that is, they can form no longer all but only certain types of cells. The latest iPS cell research however shows that certain adult stem cells can be induced into developing pluripotent cells.

Scientists postulated to achieve new insights with the use of embryonic stem cells not only for basic research in discovering (mal)developments of cells, but also for unearthing new opportunities in drug testing or cell therapies for previously incurable diseases, such as, Alzheimer's and Parkinson's. Scientists consider these stem cells to be much superior to adult stem cells in their flexibility and capacity to culture any cell of the body and that these cultured healthy new cells can regenerate or replace the damaged old cells in the body. While non-embryonic stem cell researches are ethically non-controversial and are encouraged to take place to find cures for patients, human embryonic stem cell research brings an ethical problem along with it. The fundamental ethical problem with the hESC research lies in destruction of human embryos. IVF surplus human embryos – which were once created with the purpose of implanting into the uterus for artificial pregnancies as solutions to infertile couples – or the therapeutically cloned “research embryos” are *destroyed* while extracting their inner cell mass which contain embryonic stem cells. This goes against the fundamental principle of medical ethics, namely, *primum non nocere* – do no harm.

Stem cell scientists and proponents argue that they can use death-destined surplus embryos for research because there are high-ranking noble goals, such as, finding therapies for incurable diseases. Opponents including philosophers, theologians and ethicists argue that embryos are humans who cannot be instrumentalized as a mere means to any noble end. Embryos are not things to be used as research biomaterials even to find medicine for incurable diseases.

It is self-contradictory that a group of humans (embryos) needs to be sacrificed to save another group of humans (patients). Taking an opposing stand against human embryonic stem cell research, the author makes a plea for a strict legislation to stop human embryonic stem cell research.

O-Exploring experiences and concerns about operational and ethical issues involved in AV recordings of informed consent

Shyamal Nataraj, Swaminathan Krishna

- *Ethics and Pharma Industry Venue; Main auditorium Meeting Room 2*

O-The influence of promotional activities of pharmaceutical companies on prescribing habits of physicians in Egypt- a comparison to the situation in western countries and India.

Christiane Fischer, Ms .Susan Kamal

Background: Pharmaceutical promotion activities in low and middle income countries is often not regulated or monitored. Egypt has a high population which means a lucrative market for pharmaceutical industry. Most of the pharmaceutical purchases are made out of pockets payments even by the poor and the vulnerable. Purpose: To investigate the influence of the marketing promotional activities of pharmaceutical companies on prescribing habits of physicians in Egypt. Methodology: Semi-structured, in-depth interviews were conducted to explore the perspectives of the different stakeholder, including 20 doctors, 5 pharmacists, 13 pharmaceutical sales representatives, 4 pharmaceutical marketing managers, 2 policy makers and 6 patients (a total of 50 participants). They were chosen via purposive sampling, using also snowball technique and they were interviewed over 4 weeks in Cairo, Egypt. Then thematic analysis was done using NVIVO software. Ethical Issues: The ethics of the medical practice and

rational prescribing of medicines was explored through the study. The views of pharmaceutical industry employees, doctors, policy-makers and patients were assessed through interviews on the morality of the marketing practices of pharmaceutical companies and accepting promotional gifts. **Results:** The majority of doctors and pharmacists believed that some relationship with the pharmaceutical industry was necessary for performing their professional duties and that there were both risks and benefits associated with it. They considered themselves competent in minimizing the risks and maximizing the benefits. The benefits included support for continuing medical education, scientific journal subscriptions and conference participation. Views diverged on the extent and magnitude of the risks and benefits especially in regards to the influence on patients' health. There is considerable variance in the industry's judgments of what constituted appropriate promotion; while promotion that did not have direct scientific content or benefit to the patient was considered as bribery to influence prescribing. **Discussion:** Conflicts of interest within the medical practice have serious harms towards patients and society in general. This conflict of interest is described by the WHO as: "*an inherent conflict of interest between legitimate business goals of manufacturers and the social, medical and economic needs of providers and the public to select and use drugs in the most rational way*". Patients' welfare is the primary becomes the responsibility of health care professionals to address those conflicts of interest. This can be done by understanding and responding to pharmaceutical influence on clinical decision-making through marketing and promotion. **Implication for bioethics:** Currently regulation of pharmaceutical promotion works in practice within two key regulatory models: direct government regulation and industry self-regulation. In 2004, a survey of national governments by the WHO (that include Egypt, India among other countries) found that less than one-sixth of countries had a well-developed pharmaceutical regulation system and one-third reported that they had little to no regulatory capacity. It is imperative for bioethics specialists to formulize possible harm reduction mechanisms for pharmaceutical promotion.

O-Ethical issues in collaboration with the pharmaceutical industry: How to deal with "conflict of interest"?

Mohan Isaac

Medical profession, professional associations and physicians, in particular have had a long history of collaboration with the pharmaceutical industry. The collaborations have been for a variety of professional endeavors which have included research (particularly development and trials of new drugs), scientific publishing, organization of scientific and educational events (continuing medical education, continuing professional development) and organization of conferences of professional organizations. A growing body of research has shown that physician-industry relationships can have negative consequences such as influence on prescribing behavior. In many developed countries, growing public concerns and negative media coverage about the unhealthy aspects of physician-pharmaceutical industry collaboration have lead to formulation and implementation of guidelines and legislations to govern the relationship and deal with the "conflicts of interest". The purpose of the presentation is to review the current status of physician-industry collaboration and guidelines to deal with this collaboration both internationally and in India. **Method:** A critical review of the published research and popular media coverage of issues related to physician-industry relationship, with specific reference to the field of mental health and psychiatry was carried out. The question, as the title of an academic publication stated – "if disclosure of conflict of interest is the therapy, what is the disease?" was explored. **Results:** In many developed countries, most notably in the USA, a major discourse

during the past decade was about the corrupt influences of the close connection between certain academic psychiatrists and the pharmaceutical industry – failure to accurately disclose financial payments from drug companies, “ghost writer produced, peer reviewed science”, and influencing clinical practice guidelines and diagnostic and classificatory systems. In the USA, to “shine a much needed ray of light on a situation that contributes to exorbitant cost of health care”, the “Sunshine Bill” was introduced and later passed by the Congress with bipartisan support, bringing in stringent reporting guidelines for physicians. In India, the Indian Medical Council (IMC) (Professional Conduct, Etiquette and Ethics) Regulations 2002 was amended in 2009.

Discussion: The presentation will critically discuss the issue of “conflict of interest”. All physicians have to become fully aware of, assess and acknowledge conflicts of interests. A conflict of interest occurs “when there is a risk that patient care or patient welfare will be compromised by a secondary interest”. There is great need for self-regulation at personal and professional organization levels.

O-Existing legal rules regulating conflicts of interests between medical education, research and practice and pharmaceutical industry in Germany

Dipl. Jur. Joanna Glajzer (LL.B)

Increasingly, German medical associations, patient organizations as well as politicians call for rules regulating a correct handling of conflicts of interest between the medical sector and pharmaceutical industry. Concerning this matter, a number of solutions are being proposed which differ considerably. Objective: Before implementing new rules concerning conflicts of interests in Germany it is firstly essential to get an overview of the present legal landscape. Secondly, it is necessary to assess and identify any deficits in order to take effective countermeasures. Research Methods: We conducted a systematic review of articles published from 2009 to 2013 in the German medical data base "DIMDI" as well as the legal data base "Beck- online" containing legal measures that regulate conflicts of interests in Germany. Thereafter, the legal measures were grouped according to their legally binding character as well as to persons concerned, namely medical students, researchers and practitioners. Key Results: The research has shown that the number of publications dealing with conflicts of interest between the medical sector and pharmaceutical industry increased significantly from 2009 to 2013. In the legal data base Beck- online the number increased from three publications in 2009 to 16 in 2013. In total, the research yielded 52 medical and legal publications which contained 41 legal measures. Among those, more than a half focus on the relation between medical practitioners and the pharmaceutical industry, whereas medical students are only covered by two legal measures. Furthermore, there are almost as many corporate rules almost outnumber State regulations made by the pharmaceutical industry as state regulations where the latter shows ambiguous wording and deficits. Discussion: Despite the large number of legal measures the present situation on conflicts of interest between the medical sector and pharmaceutical industry is still unsatisfactory. Especially, the coexistence of different legal procedures like intra-corporate, corporate and state regulations cause a confusing legal situation with many deficits.

- *Public Health Ethics -2 Venue; Annexe 3 – Meeting Room 1*

O-Ethics of Dental Health Screening in communities in India

Farheen Taha, Chandrashekar Janakiram

Screening is a method used for the detection of a disease at a point in its natural history when it is not yet symptomatic. The increased numbers of dental teaching hospitals have promoted the regular screening of the dental diseases through their community dentistry related activities to the communities and school children. More often dental check-up is carried out than screening of the dental diseases. Basic intention of this activity is to promote the awareness of the dental disease and their promotion of the good health. However, hidden message is to create the demand for the dental care and to find cases for the clinical activity of the institutions. The act of doing harm is more than the good in case of dental screening as patient were made aware of the diseases for s/he cannot afford the cost and time for treatment. The need of dental care demand created is easily capitalized by the dental teaching institutions for enhancing their clinical activity. The concept of screening is all the more sensational because the cost incurred by screening is extremely difficult to quantify and the effects of screening are usually measured by improvements in mortality and morbidity, which is particularly difficult to assess. Hardly, two criteria of the 'Wilson and Junger Criteria' of the principles of the screening hold good. The practice of the dental health screening must be ceased. This systematic review brings about an overview of the scientific evidence of oral disease screening, current practices in communities and ethical elements of the dental diseasing screening in India.

O-Polio eradication in India: a national mission? Exploring some ethical issues through a case study in Odisha, India

Chandi Prasad Nanda, Angus Dawson

The paper reports and discusses issues that arose from an empirical investigation into attitudes towards poliomyelitis vaccination campaigns in Odisha from three key groups: parents, community workers and those involved in planning and implementing the campaign (e.g. public health and government officials). This paper will present some broad and tentative initial findings from interviews conducted with these groups, exploring perceptions of the Global Polio Eradication Initiative (GPEI). Findings include the idea that some participants see the polio campaign as assuming the form of a national mission in India, buying into the idea that involvement is a civic obligation. This idea was apparent amongst some parents, but also visible in one senior manager, who rubbished the very idea of even exploring the context of polio campaigns and complained that even asking people about their perceptions was a deliberate attempt to harm the interests of the polio vaccination drive. Another significant dimension of our findings is an exploration of the narratives of Indian 'dissenters', those who have expressed their discontent with the polio campaign in certain pockets and communities. We seek to come to understand their reasons for caution and resistance. We compare and contrast our results with literature from elsewhere in the world that has explored the beliefs of opponents to other vaccination programs. Other issues covered in our analysis include discussion of the potential contrast between conceptions of 'global good' vs 'Indian good'; differing accounts of harms and benefits, different notions of risk, informed consent, and the presumption in favor of vaccination. These specificities within public health programs only reinforce the serious need for ethics education including bioethics as part of national curricula of professional education and promotion of international collaboration in this regard.

O-Financial Inclusion is an ethical imperative to reduce health inequities and strengthen integrity in health schemes

Sridevi Seetharam, Manohar Prasad, Seetharam MR

National Rural Health Mission (NRHM) has instituted financial incentive schemes like Janani Suraksha Yojana (JSY) for pregnant women with the objective of improving maternal health outcomes. The incentives aim to motivate regular antenatal care and institutional delivery besides addressing critical financial vulnerabilities around the time of delivery. However many mothers from marginalized communities fail to access the incentives. A study was conducted in tribal hamlets of a rural district in southern India to understand the magnitude of the problem. Method: Survey was conducted amongst tribal hamlets to assess access of pregnant women to JSY. Qualitative analysis of interviews and focus group discussions were done. Concurrently, a desk review of the scheme guidelines of JSY and financial institutions was conducted. Results: In 2013-14, amongst 56 tribal hamlets, 177 pregnant women, meeting the criteria of JSY, were identified. Of them only 106 (59%) received the JSY financial incentive, that too many weeks after the delivery. The incentives used to be paid out by open cheques to be encashed by the women. The survey found that many women did not encash the cheques or the money was misappropriated by other family members or by others through misrepresentation. To counter this, the scheme then introduced direct online transfer of the incentive to the bank accounts held by the women. However, only 46 women – a mere 26% had bank accounts, mostly in rural banks. Among the remaining 74%, the hurdles to open a bank account included geographical distance, migrant behavior, financial illiteracy, documentary requirements and requirement of minimal balance in the account. The RBI governor and PM of India, in different fora, have committed to improving financial inclusion by making special provisions of ‘Basic Savings Bank Account’ (a.k.a ‘No Frills’ or ‘Zero-Balance’ Accounts). But most women could not understand the guidelines. Managers of rural banks had no clear directions about such accounts. Of the acceptable proofs of residence, only Aadhar card and Voters’ ID were relevant to them. However, pregnant women aged less than 18 yrs were not eligible for a Voters Card. Aadhar card registration was not complete in many areas. Many women also found it difficult to fulfill the documentary requirements for Aadhar card registration. Therefore financial illiteracy and documentary requirements continue to remain hurdles for financial inclusion. Discussion: Social inequities contribute significantly to health inequities. Financial exclusion is an important, often unrecognized component of social inequity. Though financial inclusion is stated by of the Governor of RBI and PM of India as an important objective, financial illiteracy of the beneficiaries and the manner of interpretation and implementation of the guidelines by the financial institutions including rural banks have rendered the objective to remain unfulfilled. In turn, this has led to a failure of health schemes directed to address the financial vulnerabilities. Therefore close inter-sectoral cooperation and synergy is needed for effective implementation of welfare measures, improved integrity and reduced corruption in public health systems.

O-Revised National Program for Tuberculosis in India:- The slender split between ethical principles and operational convenience

Giridhar R Babu , Sathyanarayana TN, Anant Bhan , J K Lakshmi , Megha Kishore

The ethical concerns in public health programs often do not receive the same importance as the ethical aspects of biomedical research/clinical trials. There are several reasons why the

tuberculosis program in India fails to meet basic ethical principles. Research method: We studied the published literature, reports of ongoing national programs and documents outlining ethical principles that have been published by international organizations. For the purposes of this paper, public health practice is defined as "any engagement of public health professionals for implementation of public health programs". We evaluated the Revised National Tuberculosis Control Program by using a framework of ethical principles often applied in the context of research - respect for persons, beneficence and justice. The violation of any of the principles in the framework is seen as a programmatic deficiency or weak point. The principles are outlined briefly below. Results: We provide several pointers to show that ethical principles are violated in the implementation of RNTCP program. The program functions mostly on operational convenience and hence has not paid attention to the rights of people. We found that same factors, which contribute to the spread of TB and lead to more incident cases, also contribute to drug resistance. These include poor inaccurate diagnosis, poor involvement of private practitioners, poor access to proper treatment, lack of clinical follow-up of patients and poor utilization and limitations of diagnostic procedures. Most importantly, the private healthcare sectors need to be utilized and their capacity are to be strengthened for better detection and treatment. On analysis of the technical factors, the program detects only a fraction of the prevalent cases who have access to the system and not geared to detect all incident cases of tuberculosis, thereby leading to harboring of active TB in communities. The fallacious dependence on smear positivity being indispensable to accurate case detection can allow smear-negative TB infections to go unrecorded. The key underlying ethical violation here is that the basic definition of TB cases hinges around programmatic convenience, geared as it is towards calculating an estimate, and fails to effectively prioritize and address the goal of identifying all TB infections and providing treatment to them. The ethical principle of respect for persons is violated because the public and policy-makers are given either only partial or no information on which to base decisions on whether the program is truly reducing the incidence of TB or is largely concerned with decreasing the prevalence of TB cases. Discussion: Operationally convenient and practically feasible methods often ignore the ethical principles of public health programs. There is a need for examining public health programs from ethical perspective before, during and after their implementation, particularly in low- and middle-income countries. The researchers should develop ethical frameworks for application to public health programs. The health managers should be reoriented regarding ethical principles for public health programs. From the patient rights perspective, we conclude that pre-emptive ethical screening for the development and implementation of health programs might be useful.

Trust, Integrity and Stigma Venue; Nursing College Meeting Room 1

O-Interpreting Trust within the Paradigm of Autonomy

Shweta Krishnan

As law and ethics begin to be dominated by the paradigm of patient autonomy, the onus of decision-making, historically shouldered solely by the physician, shifts equally onto the shoulders of the patients. The patient emerges within this paradigm as a significant player in decisions involving his/her body, disease and illness. As these responsibilities and roles take on new meanings, it becomes necessary to remap several aspects of the transactions between patients and physicians, including 'trust.' Historically, the disparate power between the physician and the patient, arising both from the physician's significant advantage as the knowledgeable

person in the relationship as well as the one carrying the onus of making decisions, necessitated the patient to resign himself to the care of the physician, and to 'trust' him to use that power only for the patient's own benefit. But as the patient becomes more empowered, from both a need to protect himself against physicians' misuse of that power, and to become a proactive participant in his own treatment process, the significance and meaning of 'trust' has begun to change. In this paper, we examine the evolving meaning of 'trust' within the paradigm of patient autonomy. Using empirical data collected through in-depth interviews with physicians and patients in the metropolitan city of Chennai, this paper will examine the relationship of 'trust' to physician integrity, to patient's information-seeking behavior, and to patient's new role as a responsible and empowered decision-maker in the treatment process.

O-The ethical construct of Stigma: implications in training of health care professionals

Manjulika Vaz, Sandra Travasso, Mario Vaz

'Stigma' has received relatively little attention in the medical and nursing curriculum. However, a growing body of evidence, especially in the area of HIV and mental health suggests that health professionals may actually contribute to stigma. Stigma can be enacted, endorsed or accepted by one side and be internalized or anticipated by the other. We conducted a study in St. John's Medical College, among 111 medical students (N= 300), 79 nursing students (N=400), 50 diabetics and 50 TB patients. The two illnesses were chosen from a review of literature as two contrasting illnesses; TB as stigmatized and Diabetes not so. The objective was to compare the stigma perceived by the patient groups with how medical and nursing students perceived their stigma. We used the Explanatory Model Interview Catalogue (EMIC) questionnaire (Weiss M, 1997) of 15 items, which assesses perceived stigma as a composite score, but also allows evaluation of stigma across domains of disclosure and self concept, community isolation, impact on family, impact on work and impact on health. Eight focused group discussions were also conducted among medical and nursing students to explore their broader understanding of stigma and the role of the health professional in addressing stigma. The data indicates that as a group, medical and nursing students over-estimate the effect of stigma in both Diabetics and TB patients. Within each student group, 1st year students associated these conditions with greater stigma than their peers in later years. There was an acknowledgement among students that socio-economic-cultural factors of patients influence their perceptions and that 'social stigma' created a burden for patients in their work and family life. Medical students more than nursing students felt their inability to address the social burden associated with disease. The discernment between stigma in health professional students and patients has several ethical implications. Social desirability and the level of familiarity with the disease could account for some of the differences. In addition, the patients assessed were those who had come to the hospital for investigation or treatment and hence their perceived stigma could be less than those out in the community who may not be open to acknowledging their condition and receiving treatment. However, the data does call into question the possibility that by overestimating the stigma across both the diseases, medical professionals actually do harm both in their interactions with patients and the attitudes they project to society. It also raises the influence that nurses and doctors have in addressing stigma and its consequences at the societal level with stigma being the 'hidden burden' of disease. We suggest that "stigma" related to disease be integrated into teaching and that teaching needs to be grounded in social realities and changing circumstances of the disease. We additionally discuss other models of ethics in relation to diseases including Levinas's ethics which suggests that we must go beyond recognizing and understanding issues and calls for

radicalization of responsibility as 'ours' even though it is the experience and enactment of the 'other'.

O-Regaining people's trust through traditional Siddha ethical practices

Samsul Nisha Fathima, M. Dhivya, N.S. Priya devi, T. SasiPriya, S. Merish, Thomas M. Walter

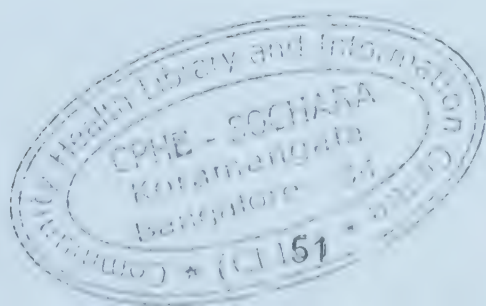
The trust of the General Public with regard to Physicians and the whole of Health care system, is gradually deteriorating due to obvious reasons such as commercialization, corporate type of approach, lack of personalization etc. This is in contrary to the older days where Physicians were seen as next to God, viewed as being part of a very noble profession, where his words were strictly followed without any hesitation and doubt etc. Among the many factors responsible for such a high professional etiquette are concepts of Patient friendly and Patient centered health care approach. Siddha and Ayurveda systems of Medicine not only concentrate in providing Therapeutic remedies but also gives extensive Prophylactic measures to be followed to lead a Eco-friendly, disease free life. If the practicing Physicians stress their patients to incorporate these Traditional Ethical commandments into the day-to-day life, the trust will be automatically rebuild to the highest possible level since the patients will be experiencing the good effects.

Discussion: The Ethical commandments deals with the essential qualities to be followed by the Physicians (like pulse reading, Transitional care, physical manipulation, safety and quality offered), aspects of food as Medicine, Sleep, Rest and relaxation techniques, Thamboolam (Conventional Betel chewing), Criteria of Physician, required qualities of drinking water, Ethical aspects of Nuptial relationship, essentials of Siddha psychiatry, Dress code, Relevance of Yoga and Pranayama to the present day and the concept of 'Kayakarpam' (panacea). The relevance of these aspects in the present day context, feasibility of the success rates, problems in implementation are also discussed in detail.

O-Achieving Physician Integrity through Traditional Siddha Medical ethics

M. Tamizhamuthu, A. Shifana Raheema, M. Dhivya, T. Sasi Priya, A. Samsul Nisha Fathima, Thomas M. Walter.

In the recent past, the World especially, we the Indians have seen the Highest attainable place for Physicians among the General Public. Even today, especially in Rural areas, people remove their foot-wear when entering into a Physician's room – a habit they follow when entering into their place of Worship. But in recent years, there are reports where Physicians are blamed, booked under Consumer act etc. Again, India is said to have one of the most corrupt medical systems in the world. The situation has become so bad that patients today approach the doctor with mixed feelings of questions regarding their efficacy & success rate, faith and fear, of hope and hostility. This leads to a distorted doctor-patient relationship, with high chances of exploitation both ways - doctors may fleece patients and, if some faults are exposed in treatment, patients or their relatives may blackmail doctors. In order to regain and experience the lost Integrity, we have put forth suggestions based on the Ethics of Traditional Indian Systems of Medicine. Conclusion: The whole of Traditional Indian systems of Medicine especially the Siddha and Ayurveda concepts are based on Ethics only. This paper highlights such important ethical guidelines to be followed to regain the high level of Physician integrity. Ethical definitions of Ayurveda (Charaka, Susrutha) and Siddha (Theriyar's view) are stated. The other concepts include need for respect to Teachers (Guru), pledging life to the service of patients, placing Patient's interest before his own, protecting Patient from harm & injustice, respecting



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Patient's right to make decisions, improving the care for Patient's wellbeing, avoiding intimacy with Patients, trying to Prevent as well as cure disease, protecting Patient's confidentiality and imparting Medical knowledge to others. The challenges in implementing the above said Ethical concepts and the desired outcome when they are implemented are also discussed in detail.

- ***Clinical Ethics Venue; Nursing College Meeting Room 2***

O-The Medical Ethics of nondirective counselling and genetic Counselling: Medicine or Ethics?

Smitha Nizar

Genetic counselling has been governed by the cardinal principle and moral imperative of non-directiveness. Adherence to nondirective approach is perhaps the most defining feature of genetic counselling. Historically, genetic counseling has relied upon the medical model of health and disease in creating and defining its mission. Practicing in a field that identifies risk assessment as one of its primary functions, genetic counselors "typically talk of the 'risk' of having a child with a particular genetic condition". It never makes the medical profession to talk about the individual of a person with disability. The nondirective approach, in fact provides the imperative to provide unbiased information to the parents about the child in womb. But when it comes to genetic counselling, on diagnosing disability, the doctors freely gives the 'problems' of such babies. However, the doctor would not inform the individual value of the baby. Instead, how "problematical will be the life" of such child is the deal for medical profession. Consequently, an automatic decision to abortion is the sole remedy proposes by medical profession. Does it not deny the parent to take an informed decision? It reduces the wider scope of the medical profession to deal with diverse minds and bodies. This paper seeks to examine whether this systemic prejudicial medical approach to life with disability negates the medical ethics that reflect its value in taking care of the wellness of all.

O-Ethical dilemmas in Genetic Counseling

Rema Devi

Genetic counseling is the process by which patients or relatives at risk of an inherited disorder are advised of the consequences and nature of the disorder, the probability of developing or transmitting it, and the options open to them in management and family planning. Genetic counseling process involves making use of the medical data to come to a diagnosis, define the role of heredity in the said disorder and give a probable risk of recurrence, consider the various alternate options that may be available, chose the appropriate course of action as considered acceptable to the family and make the family accept the problem and decide further management strategies. It is a very dynamic process and may need multiple sittings to make the patient understand their problems, and for them to chose from the options available.

Considering the patriarchic role of doctors in India, not high literacy rate in the population and the family playing a major role in decision making, genetic counseling becomes a very difficult process. How the patients or their families perceive genetic opinion, and how they deal with the circumstances varies under different situations. Division of Human Genetics, in SJMC is a cytogenetic lab with a counseling center handling about 500 cases of counseling annually. Various examples is planned to be cited to bring out the various problems the genetic counselors face, in the background of the various tests available and the high cost of the genetic tests.

O-Know thy spit: A Comparative study on the knowledge and attitudes of dental practitioners and patients on the varied ethical aspects of oral fluids (Saliva)

Tharun Varghese Jacob, Vina Vaswani, Ravi Vaswani, Shobha Kuriakose

Saliva forms a legal and ethical analogue of other bodily fluids with regard to its role in diagnostic testing, and ranks next to blood and urine in terms of frequency of use. Even though oral fluids are not similar in its makeup compared to normal human tissues or solid organs, they can provide similar types of information about individuals, which the courts and the general public deem worthy of protection, for example, in paternity determinations. Therefore, the same kinds of questions that are raised for tissues and body parts can also be raised regarding oral fluids such as saliva. The objectives of this study are: 1. To assess the knowledge and attitudes of dental practitioners and patients on the ethical issues concerning privacy and property rights of saliva. 2. To compare the knowledge and attitudes of both study groups regarding the ethical aspects of saliva. Methods: Institutional based cross-sectional study. Two paradigms will be explored through this study, which actually sheds light on patient rights to each constituent (read saliva) of his body, as well as the perceptions of doctors on ethical issues concerning oral fluids : Ownership and property rights to saliva and Privacy and the potential for genetic discrimination, given the unwarranted disclosure of confidential information. Discussion: Saliva is associated with property and privacy concerns, just like blood. The complexities of property rights will emerge because of the valuable potential for financial compensation, once a marketable product is developed from saliva. Failure to effectively inform a person of that potential may therefore represent a violation of that person's property rights. The abuse of privacy related to the exposure of genetic information obtained through oral-fluid testing poses a significant predicament, in spite of highly complex storage and retrieval systems which inevitably fail in one way or another. The main ethical dilemmas that will be stressed through this study are: Should a patient have the right to control what will be done with his or her oral fluid and to receive financial compensation when it is put to research or medical uses?

Does a person possess own his or her oral fluid? Should the person be sufficiently informed about the prospects for a commercial market, which will also constitute sufficient protection of participant/patient's legal rights?

Should mandatory training and awareness in professional and biomedical ethics be recommended to both practitioners and academicians, who also must constantly update and adapt to the rapid developments in the biotechnology of oral diagnostic testing and its broad based implications?

Outcomes: Any gap between the perceptions of dental practitioners and the expectations of the patients will be addressed, thereby improving the trust between the dental surgeon and patient. Through adequate informed consent, the contribution of saliva samples for investigative purposes which is done voluntarily with full understanding of its potential uses, salutes the ethical adage of 'Respect for Autonomy', and it safeguards to protect against unjustified disclosure of confidential information. Dental practice is characterized by a very particular bond between human beings that is structured around the problem of suffering. Awareness and training in professional ethics can lead health professionals from an asymmetric relation to their patients towards more reciprocity and exchanges. Ethical and legal protections have been

ascribed to blood due to the extensive testing of blood for medical and legal purposes. Saliva may thus be offered similar protections.

O-‘In thee I trust’ – a survey of trust in physicians in Tamil Nadu

Vijayaprasad Gopichandran, Satish Kumar Chetlapalli

Trust in physicians is the optimistic acceptance of vulnerability of the patient in the expectation that the physician will do what is best for their welfare. This study was done to develop a conceptual understanding of the dimensions and determinants of trust in physicians in resource poor developing health system settings. **Methodology:** A cross sectional household survey was conducted on a sample of 625 men and women from urban and rural areas in Tamil Nadu selected using a multistage sampling method using a pre-tested structured questionnaire. The questionnaire had 12 items covering the five dimensions of trust namely perceived competence, treatment assurance, confidence, loyalty, and respect. Items covering factors influencing trust were also included in the questionnaire. All the questions were graded in a Likert scale with 1 – strongly disagree and 5 - strongly agree. The data were analyzed in two stages. Factor analysis was done to group the factors influencing trust. Using the factor scores as independent variables and the standardized trust scores obtained from the trust scale as the dependent variable, a multiple linear regression model was fit and analyzed. **Results:** A final sample of 616 was analyzed which was comparable to the Tamil Nadu general population except a greater representation of women. The 12 item trust scale had a mean score of 21.5 (SD 10.1) out of a maximum score of 60. The factors influencing trust in physicians were grouped into five components in the factor analysis namely shared identity, behavior of the physician, personal involvement of the physician, simplicity and comfort. The linear regression analysis revealed that comfort with the physician ($\beta = 0.562$, $p < 0.05$), behavior of the physician ($\beta = 0.291$, $p < 0.05$), simple and elegant appearance ($\beta = 0.149$, $p < 0.05$), personal involvement with the patient ($\beta = 0.136$, $p < 0.05$) and shared identity ($\beta = 0.062$, $p = 0.04$) were all associated with trust in physician in that order of importance. **Discussion:** Trust is the underlying basis for a good physician-patient relationship. Upholding trust of the patients through high levels of integrity, honesty, competence, and assurance of treatment irrespective of ability to pay is an important ethical principle. Some of the essential physician related factors that influence trust in physicians have been explored in this study. Communication and behavior competence seem to be the cornerstone of healthy physician patient trust relationships. This should be practiced in the background of ethical values to provide ethical health care services.

- ***Ethics and Gender Venue; Nursing College Meeting Room 3***

O-Hysterectomy among premenopausal women- how informed is the decision to undergo hysterectomy?

Nilangi Sardeshpande

Hysterectomy in the reproductive age group is one of the areas of concern raised by women's health advocates in India. In states like Andhra Pradesh, Bihar and Rajasthan, state financed insurance based schemes like RSBY and Arogyasree schemes were found responsible for the spate of hysterectomies. Today, access to healthcare for women is faced with a paradoxical situation, where on one hand significant number of women still lack access to basic services such as good quality antenatal care and at the same, surgical interventions like caesarean sections and hysterectomies are gaining acceptance widely. In this context, the present study was undertaken

to understand how women overcome the barriers such as cultural barriers, financial barriers and physical barriers for accessing reproductive health services, where hysterectomy has been taken as an illustration of 'realized' access. In addition, the study looks into the process of decision making before hysterectomy and women's experiences about life after hysterectomy. This qualitative study covered 14 villages from two districts viz. Pune and Satara of Maharashtra state, where in-depth interviews were conducted with 44 women who had undergone hysterectomy and were not more than 45 years of age at the time of interview.

The narratives of the respondents reveal that the doctors gave cryptic information about the reproductive morbidity and various treatment options. In some cases, doctors spoke about possibility of the reproductive morbidity leading to cancer without any appropriate investigations. Given the fear of death associated with cancer, women readily accepted the option to undergo hysterectomy. In some other cases, direct hysterectomy was suggested without trying medical treatment options. For conditions such as prolapsed uterus, instead of repair surgery direct removal of uterus was advised. Sometimes doctors had given incorrect information such as the fibroids can burst inside if the surgery is delayed.

Women's recitations of their interactions with doctors raise doubts about the informed decision making. With little access to information regarding treatment options for women in rural areas, the interactions with doctors are the sole sources for getting any information. None of the doctors spoke about the possible health effects of early menopause. The study indicates that the doctors are not helping women to make informed decisions. Since hysterectomy is being posed as ultimate treatment option by the doctors themselves, gradually the surgery has gained community acceptance. Hence, women are readily undergoing hysterectomy even for problems such as pain in abdomen without any other symptom of reproductive morbidity. Informed consent is one of the prerequisites for surgical interventions; however, the study reveals that the doctors do not spend adequate time in explaining patients about either the disease or the treatment; hence the basic principle of ethics gets violated. This study stresses the need to advocate for patients' right to informed decision making.

O-Ethical challenges faced while providing care to survivors of domestic violence in routine medical practice in a town in Maharashtra

Rupali Jain

The author has established a small society of 9 women members to gradually establish some service in the small town for the survivors of domestic violence. Care has been provided to several survivors of domestic violence. This paper is based on author's personal experience in routine medical practice where the ethical challenges faced while providing care to survivors of domestic violence in routine medical practice in a town in Maharashtra have been discussed. Domestic violence against women is partly a result of gender relations that assumes men to be superior to women. Given the subordinate status of women, much of gender violence is considered normal and enjoys social sanction. Healthcare providers constitute the first point of contact for survivors of domestic violence. They play a critical role not only in evidence collection and treatment but also in identifying women who may be facing violence but may not report it. This presentation will address the causes and types of domestic violence, the consequences faced by the survivors, the ethical principles involved, the ethical challenges faced

by health care providers in countering these cases and experiencing dilemmas in handling these situations.

O-Interrogating Health Care Response to Gender Based Violence: Implication for Health Care Integrity

Deepa V, Nazia Hassan

The bias of the health care system with regard to gender, sexuality, violence and health, is well documented but so is its notoriety as an institution that is frequently violent in its practices and responses to those accessing it for care and treatment. In India, the public health institutions, are invariably accessed by women from the most socio-economically vulnerable communities.

In this context, the increasing mandate for prevention of Gender Based Violence (GBV) and responding to survivors by the health care system is a long awaited and welcome step. Although still at a nascent stage and limited in scope, both legal and policy provisions such as the Protection of Women from Domestic Violence Act 2006, Criminal Law Amendment Act 2013, the Protocols and Guidelines for Medico-Legal Response to Sexual Assault 2014 have reiterated the key role of the health care system in this regard.

As organizations, practitioners, experts, health care workers act and explore diverse strategies towards realization of a comprehensive response to GBV, it raises important questions about the integrity of the health care system. While the health care system gradually initiates implementation of response to survivors of GBV, how does it perceive those who are abused by the same system? Do these initiatives / responses have the ability to create change, reorient the system? Does the current momentum within the health care system to respond to GBV provide for a critical space for engagement vis-à-vis violent, unethical practices? The paper will deliberate on these critical concerns drawing on Sama's engagement and experience on the issue of gender based violence particularly in the context of strengthening health care system responses over the past five years as well as the organization's work and analysis around gender, public health and social justice for over a decade.

O-Enhancing Adolescent Sexual and Reproductive Health and Rights (SRHR) through Health Systems Engagement

Sunita Chowdhury, Simran Sawhney

Adolescents' access to Sexual and Reproductive Health (SRH) care is a right. It is evident from the National surveys that SRH situation of adolescent continues to have a wide array of unmet needs. Perceiving adolescent SRH merely in the context of "motherhood" and adolescent girls as "future mothers" or in the realm of "fertility control", or merely as an investment in the "future workforce for the country" causes a restricted response to their needs and excludes major health concerns of adolescents groups. Adolescents continue to face major constraints in making informed choices about their health and have limited access to health services. Gender inequality is still a wide-spread phenomenon in the society making female adolescents more vulnerable in comparison to their counterparts. The Adolescent Reproductive and Sexual Health (ARSH) Strategy, 2006 launched under National Rural Health Mission followed by more recent Rashtriya Kishor Swasthya Karyakram, 2014 (RKSK) provides the framework for the adolescent sexual and reproductive health services and recognizes adolescents as a group with special and distinct needs beyond maternal health. The Adolescent Friendly Health Clinics (AFHC) was established

in the public healthcare facilities for catering quality health services to adolescents. This paper presents the key concerns emerging from an assessment of the ARSH services in public health facilities conducted in five states i.e. Rajasthan, Chhattisgarh, Odisha, Madhya Pradesh and Jharkhand. **Methods:** In-depth discussions/ interviews were conducted with 31 health care professionals in the five States along with visiting 13 Adolescent Friendly Health Clinics (AFHCs). Interviews were held with 46 Community Based Organizations to understand the concerns of adolescents along with the discussion with the adolescent groups (boys and girls) in the community to understand the barriers contributing to their limited access to the health care facilities. **Results:** The assessment revealed that SRH services for adolescents is lacking in public healthcare system. Any space or initiative for adolescents requires adequate and quality infrastructure including human resources and comprehensive services that are provided in an adolescent-friendly environment. Given that the AFHCs are largely located at secondary and tertiary level facilities, they are invariably accessed only by those adolescents living nearby, limiting access to a small percentage of adolescents. This is further limited as a result of social and gender norms that restrict access for girls. As a consequence of the dearth of information and awareness about ARSH/RKSK even amongst health care providers, other service providers such as educational institutions, non-government organizations, etc. the linkages between these institutions, adolescents and ARSH centres are extremely skeletal. **Conclusion:** Adolescents' involvement in planning, feedback is important to ensure that their needs and issues are articulated and adequately addressed. Involvement of diverse groups of adolescents from varied contexts and realities must be ensured towards improved access. The AFHCs are dedicated spaces for adolescents to access not only for clinical services but also for information regarding their health and lives. Given the dearth of such spaces available to them, these centres should provide comprehensive services and must not be limited to clinical care alone.

Posters: Main Auditorium Foyer

A historical evaluation of the discourse on ethics in medical education in India between 1915 and 1965.

Tom Mishaal, Mario Vaz

Medical colleges in India today do not have a stipulated medical /clinical ethics curriculum mandated by the regulatory body, The Medical Council of India (MCI). It is our suggestion that the inability of the MCI to address this urgent need (until recently, in its Vision document) is, in part, situated in a historical context. The paper explores the discourse related to ethics and medical education during much of the 20th century both in the pre-independence and immediate post-independence period.

In 1916, the Indian Medical Act was promulgated, and underwent revisions in 1933 and 1956. The primary intent was to ensure uniformity in medical education for the award of degrees. Despite the observations of Sir Hehir on "The Medical Profession in India" in 1923, where he highlights the lacunae of Indian Medical Colleges in comparison to those in the UK where "the ideals are loftier, the sense of duty and responsibility more fostered....and almost insensibly the principle of service to others, are engrafted," the major parts of the implementation of these Acts were achieved through a rather constrained prism of critical evaluation of medical education in terms of personnel and in the 'traditional' course content, and through 'inspection'. The MCI today continues to follow broadly the same mandate, without a reflection on changing times and needs.

In the 1940's the Bhore Committee Report was published. While not identifying specifically the need for medical ethics in the curriculum, it was important in that it expanded the role of the 'basic doctor' to include "extending his sphere of public utility" – in doing so, the Bhore Committee Report in all of its volumes underlines the principles of social justice and equity. It also called for the "fullest development of humanistic and scientific talents" and that "medical students will be encouraged to develop those qualities of mind and character that make a good doctor." In 1950, The World Medical Association published a report on the "Standards of Medical Education" in 26 countries of the world including India. The only reference to Ethics is whether students take an oath on graduation, suggesting a global deficit in the need for formal education in ethics. By the 1950's The Medical Council of India and the Indian Medical Associations had formulated clear codes of medical ethics but the assumption appears to be that students would somehow imbibe these values during the course of their medical education. However, people like Maj Gen SL Bhatia had by 1954, started suggesting that "the teaching of medical ethics should form an important part of the medical curriculum." The XIV World Health Assembly at New Delhi in 1961 which was the focus for introspection on India's health care needs does not elaborate on ethical concerns in any of the writings of its souvenir. However, personal writings of influential people like RV Sathe and Lt Col. V Srinivasan indicate their concerns about the ethical and humanistic dimensions of doctors of the time.

In close to 100 years since the introduction of the Indian Medical Act, little has been done to formally introduce ethics into the medical curriculum. It would appear that the medical profession has failed to address this pressing societal need. Greater pressure from civil society may be needed to bring about change.

P-Genetically modified food crops – an ethics inquiry into the policy process and stakeholder concerns

Adithya Pradyumna

The decision-making process on the question of introduction of genetically modified (GM) food crops in India has been a heated one. GM food crops have been either restricted or banned in several countries including the European Union. The basis for the support and opposition of this technology, and the various aspects of the decision-making process in India would benefit from an ethical inquiry. Research method: The stakeholders considered for the inquiry: seed companies, government, "expert" committee, farmers, civil society, scientists, and potential consumers of these foods. This preliminary analysis of secondary data used principles of applied ethics (biomedical research ethics and environmental ethics). Results: The argument for support of GM crops is made largely around two issues: reduction in malnutrition, and increase in income for farmers. These claims are unsubstantiated by evidence. While malnutrition in India is not related to food production or availability, the alleged higher productivity, reduced input costs, appropriateness for Indian agricultural sector, and safety for consumers is highly contested. The Genetic Engineering Approval Committee, a body that has repeatedly recommended the field trials of GM crops, is comprised largely of scientists biased towards GM crops. Contamination of native varieties with GM material can impact productivity negatively, and has led to lawsuits by seed companies alleging theft on intellectual property by innocent farmers in the Americas. Traditional varieties of food crops could get further depleted, potentially leading to increased vulnerability of crops and farmers to various threats. Dependence

on companies for seeds will increase, leading to increasing costs and loss of food security. From the consumers' perspective, safety is still unclear. Labelling of GM food (as practiced in some countries) would be necessary to provide choice to consumers who want to avoid it. Discussion: Conflicts of interests were found in the decision-making body. Utilitarian claims for malnutrition reduction and increased income are on unsubstantiated grounds. Forums for open discussion with decision makers are necessary. Contamination of crops undermines the autonomy and sovereignty of farmers. The potential catastrophes that the self-sustaining Indian agri-sector could suffer by adopting GM crops and potential health impacts also bring the need for application of the Precautionary Principle. Consumption of these foods will not be unlike a poorly designed experiment, without consent of participants (violation of autonomy and non-maleficence) and information on control group. Consumer education on this issue is necessary for their participation in this debate. These and several other aspects of the clearance procedures require further detailed and nuanced ethical inquiry.

P-Plagiarism check using easily accessible software - a personal experience

Jean Fredrick

A part of scientific misconduct involves "...*fabrication, falsification, or plagiarism in proposing, performing, or reviewing research or in reporting research results...*" Plagiarism is feared to be the most common practice of these. 'Plagiarism' in Latin means "kidnap." The World Association of Medical Editors (WAME) defines plagiarism as "... the use of others' published and unpublished ideas or words (or other intellectual property) without attribution or permission, and presenting them as new and original rather than derived from an existing source." Several software such as 'Turnitin', 'iThenticate' and 'Grammarly' are used by institutions and publishers to screen for plagiarism in submitted dissertations or articles. These are, however, paid software and may not be accessible to all. There are, as alternatives, free software such as Viper, PaperRater.com, etc., which are available online. However, in my experience, only a relatively small proportion of people are aware of what is available. This is a personal experience of checking a part of the "review of literature" in my thesis for plagiarism using Grammarly, PaperRater.com and Viper. Viper and Grammarly reported 4 % and 3% plagiarism respectively. PaperRater.com originality check indicated an 80% originality score. A more graphic comparison of these software will be provided. Apart from originality checks these software also provide us help with grammar and vocabulary. eTBLAST is a software which is also available free online to check for originality. This software also helps us to find the keywords and most similar articles published as well as to identify pioneers in that field of study and to compare two text documents for similarity. Knowledge of plagiarism check using software among students and teachers will help them reduce the return or rejection of articles from publishers, and promote integrity in the conduct of research.

-Ethics Of Using Type2 Oral Polio Vaccine In India

Gayakrishnan Thayyil, Vidya Kuniyil

Polio eradication is currently defined as the absence of a single indigenous case of Acute Flaccid paralysis (AFP) attributable to wild poliovirus in a defined geographical area for a period of three consecutive years. In India the last cases of paralytic polio due to wild virus was detected in January 2011 and no wild poliovirus has been detected from any source in the country after that. India has been declared polio free by WHO in 2014. Oral Polio Vaccines (OPV) have been used as the main tool in the polio eradication program. Once wild poliovirus transmission has

been interrupted, the only poliomyelitis due to poliovirus will be caused by OPV, which are known as vaccine-derived polioviruses (VDPVs). In India we are still using trivalent OPV (tOPV) which contain live attenuated virus of type 1,2,3 which has got a risk of VDPVs. Aims: Evaluate the risks and benefit due to continued use of tOPV in national program on the basis of ethical backgrounds. Methods : Authors searched, reviewed the full text of the available published literature on polio eradication via PubMed and the web sites of major international health agencies. Results: Operationally, eradication of globally, the last case of poliomyelitis caused by naturally circulating Wild Polio Virus (WPV)type 2 occurred in India in 1999, type 3 in 2010 and type 1 in 2011. The last detected WPV from sewage testing in India was in November 2010 proving that there was no environmental transmission. Thus no wild poliovirus has been detected from any source in the country after 13 January 2011. As reported by WHO 97.1% of the 628 VDPV cases reported during 2006–2013 from all over the world was due to type 2 . After 2011 all VDPV reported from India was due to type 2 virus from tOPV which contain type 2 virus. In 2013, the Global Polio Eradication Initiative (GPEI) declared that OPV would be withdrawn in phases, first type 2 and later types 1 and 3. The type 2 in trivalent OPV was inhibiting immunity to types 1 and 3. Pakistan, Afghanistan and Nigeria where naturally circulating wild type 1 and 3 was reported are currently using OPV , which contain no type 2 viruses . Most of the developed countries and countries with high routine coverage that switch from OPV to IPV in their national immunization programmes had consistently eliminate VDPV from their countries by assuring immunity from wild polio. Discussion: The continued use of trivalent Oral Polio Vaccine (tOPV) in the polio eradication program poses the risk of paralysis from type 2 VDPV. In order to mitigate this risk, it is important to discontinue tOPV and switch to bivalent OPV (bOPV) in both routine immunization. VAPP occurring in the absence of WPV polio is ethically untenable. In the absence of wild poliovirus low risk of vaccine derived paralytic polio is no longer socially acceptable. Moral considerations of public health ethics are providing benefits, avoiding /preventing /removing harms and producing maximum balance of benefits over harms and other costs. On the basis of Harm principle, there is no risk of paralytic polio anywhere in the world due to type 2 since last fourteen years. OPV2 use is not preventing harm of others but producing harm. Other available cost effective options are available. So continued use of type 2 in OPV has got no public justification.

P-Knowledge, attitude and perception of physicians with respect to four principles of bioethics vis-à-vis the knowledge and perception of health care seekers at a tertiary care hospital in Mangalore.

K. Leena Pramod, Vina Vaswani, Ravi Vaswani

Physicians are bound by the oath of Hippocrates to take good care of patients, but unfortunately most of them don't remember its content and those who do, do not follow it. Similarly even though, about 90% doctors have heard about the code of medical ethics only 50% have read it, even in part. The four principles of bioethics proposed by Beauchamp and Childress are being universally followed all over the world; namely autonomy, beneficence, non-maleficence and justice. Each of these principles addresses a value that arises in communications between physicians and health care seekers. Media and internet have played important role in creating awareness among the health care seekers regarding their rights. Health care seekers have started questioning the health care providers regarding the treatment. The unethical conduct of certain doctors has created a rift between the physicians and the patients, which needs to be taken care of by including ethics in all branches of medical studies stressing on the basic principles of

bioethics. This needs to be implemented with immediate effect as the budding doctors tend to forget to apply these basic principles while treating patients. Studies conducted in India with regards to gap analysis of perception of ethical practices between doctors and patients are few, so this study attempts to know the knowledge, attitude & perception of physicians and health care seekers towards the principles of ethics and the steps to be taken to fill the gap between the 2 groups. This will help physicians understand the expectations of their patients and thus work towards bringing both parties on to the same ethical page. Materials and Method: A pre-validated questionnaire was given to 50 doctors and 50 patients of a tertiary care hospital to assess their knowledge, attitude and perception towards the four principles of ethics, using and the results were compared to see if there is a gap between the two. A descriptive statistical analysis was used to analyze the data. Results and discussion of the study will be presented at the conference and this will help us better understand the expectations of health care seekers.

P-Instructions to authors in biomedical Indian journals

Anup Bhat, Akash Shah, Swathi G S,

Journals must provide clear instruction to authors, not only to facilitate submission but also to promote ethical research and avoid publication misconducts. Authors are expected to thoroughly examine these instructions and adhere to them. We aimed to study the details provided under the instruction to authors section of biomedical Indian journals. We report the frequency of journals providing details about the recommendations made by the International Committee of Medical Journal Editors. Research methods: Biomedical Indian journals indexed in PubMed were identified from the National Centre for Biotechnology Information (NCBI) database. Details mentioned under the instructions for authors section in the website of each journal were noted. We specifically looked whether the journals provided details about the following- statement on ethics (Human and animal ethics), research guidelines to report various studies (CONSORT, STROBE, PRISMA, MOOSE and STARD) requirement for trial registry for clinical studies, authorship guidelines, copyright transfer and reporting conflict of interest. Results: A total of 74 biomedical Indian journals were identified. Instructions to author section were provided by 71 journals (95.9%). Statement on ethics approval for human and animal studies were mentioned by 60 (80.5%) and 50 (70.4%) journals respectively. Research reporting guidelines (CONSORT) and clinical trial registration for randomized clinical trials were mentioned in 36 (50.7%) and 28 (40.8%) journals respectively. Guidelines for reporting other study types (STROBE, MOOSE or STARD) were reported by 18 (25.3%) journals. Authorship criteria were mentioned in 48 (67.6%) journals, of which only 2 journals mentioned the updated ICMJE criteria of authorship. Need for informed consent and assent were mentioned by 52 (73.2%) and 39 (54.9%) journals respectively. All journals mentioned details about copyright, whereas mention about conflict of interest was made by 63 (88.7%) journals. Discussion: It is encouraging that almost all biomedical Indian journals provide instructions to author section and a large number also give importance to ethics and conflict of interest reporting. There has also been an improvement in the information provided in this section compared to a previous study conducted in similar subspecialty. However, there are few aspects that are still not given the required focus. Research guidelines to report studies are not mentioned in several journals. Requiring clinical trial registration for clinical studies and adherence to ICMJE guidelines for authorship require more importance. We hope that in future, journals provide more detailed information for authors to facilitate ethical research.

P-Upholding patient's confidentiality – An Experiential account of a Psychiatrist's Plight

Johnson Pradeep. R

This case report is my experiential account - of what I underwent after I was threatened by the extended family when I was trying to uphold the confidentiality of my patient. Generally, all doctors are ethically bound to ensure confidentiality of their patients - both the information obtained during history taking and the medical case records. In spirit, the ethical obligation of the doctor is clear – both in terms of maintaining confidentiality and circumstances wherein confidentiality can be broken. However, in clinical practice the procedure to be followed for disclosure of information is sometimes clouded by threats, harassment and litigation. And paths to redressal of grievances can themselves be perceived as a source of harassment to all involved. Finding a solution which can protect the rights of patient, family members and even the treating doctor is a challenge.

P-Informed consent in medical research: perceptions among medical students': A survey

Sripada G Mehandalei, Uma Kulkarni, Vina Vaswani,

Informed consent is a major safeguard to protect the research participants by including basic principles of ethics namely, autonomy, beneficence, non-maleficence and justice. A thorough understanding, agreeing and executing of informed consent is essential in order to assure that medical research is conducted in an ethical way. There are several reports indicating substantial lack of awareness about informed consent among medicos. As data is not available in our context, current work was undertaken to evaluate the knowledge level of medical students in different aspects of informed consent and their estimate of adequacy of understanding the same. **Methods:** A questionnaire consisting of two parts, first to elicit experience of the participants in the field of research while second, with seven items covering various aspects of informed consent as 30 subunits was distributed to 207 students belonging to final year MBBS, internship and post graduation through their representatives, after institutional ethical clearance. No details pertaining to personal information or identity of the student were collected, though they needed to sign the questionnaire at the end, as part of consent for the study. A drop box was kept at the main entrance of the hospital to collect the duly filled response sheets. The participation was totally voluntary and there was no personal contact between the investigators and participants. Data was analyzed using Microsoft office excel 2007 software. **Results:** Of the 204 responders, only 17.6% had completed a research project, 11.2% were presently conducting a research project and 32.8% of the participants had attended a research workshop and 28.3% had themselves been research participants. Though majority were aware of need to divulge information like refusal to consent, confidentiality, benefits, withdrawal, compensation and publication details, experience of researcher, financial interests and funding were thought be not required to be informed to the participant. Similarly, autonomy principle was not well understood as evident from the confusion regarding appropriate consenting authority in cases of orphans and inmates of hostels. When enquired about need for informed consent before research, the most frequent response (38.7%) was 'to protect the interest/autonomy of the research participant'. The next frequent reason (33.8%) was to 'follow standard operating procedures', while 17.6% felt that it was for the sake of safeguarding the researcher from being sued in case of conflict. Only a third of respondents felt the consent is to protect the subject. The knowledge level was only average, (17.3 out of 30) and there was no uniformity in the source knowledge (faculty and peer and not text). **Discussion:** The results

showed very low exposure to research and research methodology. Participants were not adequately sensitized to need for different nature of consent especially ones like study on sexual practices. These findings suggests a need to upgrade the curriculum to improve the bio-medical ethics content, sensitize the student population to various issues encountered in medical and research ethics during routine clinical practice, improve the skills in obtaining the informed consent and periodic evaluation to assess the adequacy of such measures with particular emphasis on informed consent.

P-Sensitizing intern doctors to ethical issues in a doctor-patient relationship ***Nilima Shah, Ritambhara Mehta, Kamlesh Dave***

Doctors have been considered noble professionals, traditionally, next to God. However unethical practices by doctors are on the rise. One way to change this scenario is to impart education on ethical principles to medical students. The MCI has directed in its Vision 2015 document to have a foundation course on ethics. But, currently, most of the institutes in the country, including ours, do not have a formal curriculum on ethics. As a small start in this direction, we thought of sensitizing our intern doctors to ethical issues in a doctor-patient relationship. Description of Innovation: Intern doctors are posted in the Department of Psychiatry for 15 days in small groups of 10-15. A 4 – hours long interactive session, with discussions on case scenarios on ethical issues in a doctor-patient relationship, was taken. Five main principles viz. the code of conduct, confidentiality, truth telling, autonomy and informed consent were included. A pre-post MCQ test (validated and pilot tested) was taken to assess their knowledge and attitude on these issues. Later, the ethical issues learnt were tested by 5 OSCE (Objective Structured Clinical Examination) stations, one each on the five principles discussed; with trained resident doctors as simulated patients. Lastly, a feedback questionnaire was filled up by the participants. Results : 45 intern doctors were enrolled in the project. There was an average of 37% increase (from 51% to 81%) in their MCQ scores after the teaching-learning session. The average score of all the OSCE stations was 71 %, with average individual station scores being: Truth-telling and Autonomy - 50%, Code of conduct -77%, Confidentiality and Informed consent- 80%. Out of 45 interns, the performance of 10 was rated as excellent (81-100%), 30 as very good (61-80%), and 5 as average (41-60%). There was a weak co-relation between post-session MCQ scores and OSCE scores ($r=0.16$). Their feedback revealed that they were satisfied, and their knowledge, attitude and skills on the topic increased after the activity. They found the group discussion on case scenarios very useful and interesting. They viewed OSCE as an opportunity to practice skills. They were sensitized to the ethical issues and expressed a desire to learn more. They said that this learning was likely to influence their decisions in future clinical practice. A suggestion came up that there should be a platform where such issues could be raised and discussed. Discussion: This small intervention revealed that interactive teaching on ethics resulted in an improvement in the knowledge and attitude on the topic. The students were sensitized and eager to learn more in the field of ethics. Both, knowledge-based and skill-based teaching-learning activities should be incorporated in a curriculum on ethics in a doctor-patient relationship, as effective interpersonal and communication skills are required in addition to the knowledge about ethical practice. Apart from sensitizing the budding doctors, we need to provide continuous reinforcement, feedback and guidance for ethical practice.

P-Assessment of knowledge on bioethics in medical students and teaching staffs and their perception on bioethics as a subject

Swapnil S Agarwal, Alpa Gor, Barna Ganguly

Basic principles of medical ethics are not discussed elaborately in conventional curriculum of our country, except in a few medical colleges. In order to create a proper ethical environment in medical field both in therapeutic as well as research field, training on bioethics at grass root level is necessary. Aims and objectives: To analyze the extent of knowledge on bioethics amongst the undergraduate medical students, interns and also the teaching faculties of medical college and their perception in studying Bioethics as a subject in undergraduate medical curriculum. Methodology: A questionnaire was designed with an aim to find out the level of concept and knowledge with activities related to ethics. The study participants were divided as group I – Undergraduate medical students and interns (total 225) and group II – Teaching staffs (100). The questionnaire study was started only after the permission of institutional ethics committee. Results: There were 76 respondents from student group and 22 from the interns, total number were 98 from group I and 41 faculties from group II. 77.55% of the respondents from group I and 82.93 % from group II expressed the awareness of ethics, whereas 21.42% from group I and 7.32% from group II were not aware of bioethics. There was a mixed opinion on acceptance of gifts by doctors from pharmaceutical companies from students' group. Majority of the faculty (85.37%) were not in favor of accepting gifts. As regards to need of training on bioethics in undergraduate medical curriculum, 70.41% and 70.73% from group I and II respectively were in favor of including this. Conclusion: The present study shows that there is some knowledge on bioethics amongst the students' level in a dormant stage. Some of the students agreed upon the necessity of teaching/ learning bioethics and opted for more interactive sessions. The respondent faculties also agreed upon the fact of introducing the same as a compulsory subject with the reasons as (i) to avoid malpractices (ii) to reduce medical negligence (iii) establishment of rational therapy (iv) to reinforce the moral duty of a doctor.

Workshops: Day 2, 12th December, 2014 2:00 to 4:00 pm

WS-Clinical Ethics Committee: A Way to Promote Ethical Practice?

Venue: Main Auditorium Meeting Room 1

As medicine has evolved into hospital centered, multi professional and technology-driven healthcare delivered by trans disciplinary teams, ethical decision-making in clinical situations has become increasingly complex and doctors struggle with choices that weigh treatment options, patient's wishes and ethical practice in emotionally charged clinical situations.

Given the current limited attention to ethical standards outside of research and absence of undergraduate teaching in medical ethics, the physician is barely equipped with skills in ethical decision-making. On the other hand, the patient, family and wider society expect that crucial decisions on patient care and health resource be based on sound legal, ethical and scientific principles.

The role of the Clinical Ethics Committee (CEC) or Hospital Ethics Committee is to provide physicians with guidance and ethical solutions in difficult clinical situations, drawing from legal frameworks, codes of ethics, hospital policy, standards of care and moral consensus in order to ensure the 'least harm' and the 'best outcome' for the patient.

Though well established in the United States, UK and Europe, there is insufficient data regarding the existence, functioning or usefulness of Clinical Ethics Committees in the Indian hospital setting. While Institutional Review Boards (IRB) engaged in review of research studies and clinical trials, need to be registered, there is no such requirement for Clinical Ethics Committees. In some cases, the IRB doubles up as the CEC when called upon to assist in patient care ethical dilemmas.

Clinical Ethics Committees can possibly benefit both patient and doctor by promoting awareness of ethical standards, adherence to legal norms, sensitization to patient's needs, development of hospital policy and sharing responsibility in difficult clinical decisions. The deliberation and support of the individual doctor by a team can promote a culture of ethical behavior in clinical settings.

This workshop will provide the opportunity to evaluate the relevance and need for Clinical Ethics Committees in the hospital setting in India.

Expected outcomes:

1. The workshop will initiate a debate on the need for Clinical Ethics Committees in hospitals today.
2. A list of recommendations on functioning of Clinical Ethics Committees.
3. A description of the larger role of Clinical Ethics Committees in promotion of ethical practice in clinical settings.

List of facilitators:

Dr. George Korula

Professor Of Obstetrics and Gynaecology

Head of Unit, Reproductive Medicine Bangalore Baptist Hospital

Member Clinical Ethics Committee, Bangalore Baptist Hospital

Dr. C.S. Rajan

General Surgeon

Ex-Medical Superintendent, St. Marthas Hospital

Chief of Medical Services, Columbia Asia Hospital

Dr. Mabel Vasnaik

Consultant and Head, Emergency Medicine, Manipal Hospital

Chairperson, Accident and Emergency of Manipal Health Enterprises

Ex-Head, Department of of Emergency Medicine, St. Johns Medical College Hospital

VS-Clinical Ethics Case Consultation- A 3 Hours Workshop

Venue: Main Auditorium Meeting Room 2

Clinical ethics is a practical discipline that provides a structured approach to assist physicians in identifying, analyzing, and resolving ethical issues arising in clinical medicine. In developed countries, health care institutions employ either a clinical ethicist, or a Clinical Ethics Committee (CEC), comprising of a group of health care providers and administrators. In countries like

Pakistan and India, where clinical ethics is relatively a new field, employing CECs is a practical approach as it shares the responsibilities, provides a support system and encourages mutual growth while at the same time helps in resolving various ethical dilemmas/issues arising in clinical care. This workshop aims to help the members of CECs in providing case consultation following a structured approach.

Who can attend?

- Members of the clinical ethics committees,
- Health care providers and administrators interested to develop clinical ethics committees in their institutes.

Objectives

- At the end of the workshop, the participants will be able to:
- Identify an ethical issue and distinguish it from non-ethical problems.
- Apply a structured framework to formulate a recommendation for a clinical ethics problem.

Pedagogy

Workshop will employ interactive methodology to achieve the objectives. A case-based approach where cases and examples encountered in real life will be used. Standardized patients will be used to emulate real life scenarios for practice of the framework. Pre and post tests will be done for self assessment of the participants.

Facilitators:

- **Robyna Irshad Khan**, Associate Professor, Department of Anaesthesiology, Aga Khan University, Karachi
- **Aamir Jafarey**, Associate Professor, Centre of Biomedical Ethics and Culture, Sindh Institute of Urological Transplants, Karachi
- **Waqar Kashif**, Associate Professor, Department of Medicine, Aga Khan University, Karachi

WS-Public Health Ethics Workshop/Symposium

Venue: Nursing College Meeting Room 1

Public health ethics is a new focus for public health, concerned with the values, ideas, assumptions and frameworks that underlie population and preventative health. It differs from medical ethics and *begins with recognition of the values at the core of public health, not a modification of values used to guide other kinds of health care interactions*

Public health ethics is about the values, principles, and frameworks that underlie population and preventative health. To develop skills in clarifying and communicating the 'why' of public health (the ethical assumptions and values that underlie and justify public health) and the 'how' of public health ethics (frameworks useful for tackling a particular public health issue in an ethical way).

Bioethics is relatively new in India with momentum gaining from the last decade. Most of Bioethics activities are limited to Clinical and Research ethics. Ethics in public health is very

new word among the public health practitioners in India, if not for few people in this cohort. The National Bioethics conference is ideal platform to enlightened or brain storm the need of public health ethics education and practice in India.

Objectives

- Bioethics and public health
- The philosophy of public health ethics and its values
- History of public health ethics : Specific case-studies
- Perspectives on public health ethics
- Ethical Evaluation of Public health policy/program
- Applied public health: frameworks for resolving public health issues
- Need of Public Health Ethics education/ curriculum in India

Workshop coordinator

- **Dr. Chandrashekar Janakiram**, Professor , Epidemiology,, AIMS Cochin & Consultant to RGIPH, RGUHS Bangalore India
- **Dr Mala Ramanathan**, Additional Professor , AMCHSS, SCTIMST Trivandrum India
- **Dr John Porter**, Professor of International Health, London school of Tropical Medicine and Hygiene , UK

WS-Good Authorship Practices (GAP) - Filling in the gap

Venue; Cafeteria Meeting Room

The workshop aims to provide participants with an understanding of good authorship practices and issues related to it. It will empower participants with methods to rationally discuss and negotiate authorship concerns. It will provide participants with opportunities to discuss authorship issues. This workshop aims at building your capacity so that you can be the academic leader in your institution / University / organization that can provide leadership for initiating and sustaining the changes needed and disseminate the awareness.

Objectives:

The participants will be able to:

- . list and determine the good practices related to authorship
- . evaluate the role of institutional authorship policy
- . draft institutional policy with regard to authorship

Who should attend?

Middle and Top-level Faculty who are in a leadership role (HOD, Academic Directors, Course Directors, Deans or Registrars etc.) who have been given the task of transforming the research and publication practices (or aspire to be the one who can take up this role) so that your institution produces ethical research based on good authorship practices. Reviewers of journal, editorial board members, potential researchers and authors may also be included.

Methodology:

Powerpoint lectures

Case studies,

Discussion.

Participatory and interactive small group sessions.

Appreciative inquiry.

Reflection on how the new learning can be applied by the participant in his/her institution/organization.

Facilitators:

Dr. Animesh Jain

Dr. Rashmi Jain

Abstracts Day 3, 13th December, 2014

Workshops, 11 am to 1 pm

WS-Corruption in healthcare- Working towards solutions

Venue: *Main Auditorium Meeting Room 1*

Facilitator/s: *Anita Jain* [The BMJ], *Christiane Fischer* [MEZIS]

Purpose: To develop skills to identify sources of corruption in various dimensions of the health sector, understand the factors at play, and devise creative and workable solutions to tackle the problem at individual, institutional, and policy levels.

Process: The workshop will be structured so that participants and facilitators learn from each other with adequate time for group work and discussions.

Expected outcomes: Participants will appreciate the impact of corruption in the health sector, and gain an insight into analyzing the problem of corrupt practices. They will learn about various tools, some tried and others appealing, to take forward in their settings.

WS-Indian Bioethics Conference

WHO session on integrity and corruption in healthcare

Venue: *Nursing College Meeting Room 1*

Transparency and integrity in the provision of health care and in the pharmaceutical sector are key concepts in public health ethics. Corruption decreases the funds that are effectively available for public health programs and medicines, and a high level of unethical practices has been shown to have a direct impact on health outcomes. This is why tackling these practices is of crucial importance, and WHO has had long-standing programs in this area.

This session will explore the concepts and modalities of transparency and integrity, and how they can lead to improvements in inefficiencies in healthcare. It will provide an overview of WHO's activities, as well as perspectives from Singapore, India, and Thailand illustrating the relevance of the issues at country level, and recommend best practices on how to address corruption in the health sector.

Program:

Time	Topic	Speaker
120 min.		
20min.	Introduction	Andreas Reis, Global Health Ethics Unit, WHO Geneva
25 min.	The Good Governance for Medicines (GGM) programme in Thailand	Chanvit Tharathep, Ministry of Public Health, Thailand
25 min.	Governance of the pharmaceutical sector in Singapore	Calvin Ho, Centre for Biomedical Ethics, National University of Singapore (WHO Collaborating Centre for Bioethics)
40 min.	Integrity and governance in the Indian	Vijay Gopichandran, School of

	health sector	Public Health, Tamil Nadu, India
	WHO India perspective	Madhur Gupta, WHO India Office
10 min.	Conclusion	Chair

Facilitator: Dr. Andeas Reis, MD , MSc

WS-Accountability for Reasonableness: Addressing Challenges in Public Health by Harmonizing Ethics, Economics & Evidence

Venue: Nursing College Meeting Room 2

Evidence-Informed Public Health, especially in the context of resource constraints, poses certain challenges. While there have been concerted efforts in incorporating "Evidence" and "Economics" in various priority setting processes, Policy Makers and Program Managers often feel a gap in addressing the "Ethics" of decision making. Defensive practices to mitigate the risks of "corruption charges", without considering the public health needs poses further challenges too, which is equally harmful if not more than corruption per se. It is in this context that a framework like the Accountability for Reasonableness (A4R) becomes handy for decision makers to ensure a fair and legitimate process in priority setting.

The A4R framework stipulates that any decision making process to be fair and legitimate must satisfy four conditions namely, Relevance, Publicity, Revision, and Enforcement. It has demonstrated the potential benefits of ethical considerations in dealing with the "how" part in the decision making process especially in resource-limited settings. The addition of a fifth condition - Empowerment - (A4R+E) to the original four conditions provided further strength to the framework. This addition is an important step in respecting autonomy by virtue of citizens and groups being empowered to participate in the process.

Objectives:

1. To understand the elements of the modified Accountability for Reasonableness Framework (A4R+E)
2. To apply the elements of A4R+E in participants' unique Policy and Program contexts
3. To predict the limits and risks while using A4R+E and explore ways to mitigate them

Facilitator: Dr. Nabeel M K

WS-The Internet and Digital Ethics: New Challenges for Practitioners and Clients

Venue: Nursing College Meeting Room 3

The growth of the internet and social media throws up new clinical and ethical challenges for practitioners. Emails, Whatsapp, LinkedIn, Facebook, Twitter, blogs, Google searches: Digital technology has a growing presence in our personal and professional lives. This involves complex questions about the distinctions between the personal and professional aspects of our personas, the intrusions of technology within and beyond therapeutic sessions, interactions with clients in the online space and potential, often inadvertent, ethical and legal transgressions.

Purpose: The workshop aims to sensitize participants to ethical challenges that may arise in contemporary practice involving online presence and interactions. These issues are particularly relevant for practitioners in disciplines like psychiatry and clinical psychology as well as other specialties involving prolonged/intimate contact with clients.

Processes:

The workshop will include interactive discussions, hypothetical case vignettes, group activities and experiential tools.

Expected Outcomes:

After the workshop, participants will;

- Be able to identify common ethical challenges arising from client-practitioner interface in the online space.
- Understand the distinction between personal and professional activities on the internet and the potential boundary issues that may emerge.
- Learn to apply an ethical decision-making approach in managing one's online presence.
- Acquire knowledge about professional guidelines related to digital ethics.
- Formulate a social media policy relevant to their practice.

Facilitators:

Dr. Poornima Bhola is a clinical psychologist-therapist who has worked in both general hospital and in psychiatric hospital settings. She works as an Associate Professor in the Department of Clinical Psychology at NIMHANS, Bangalore. She has recently completed a project and is supervising doctoral work; both focused on ethical issues in psychotherapy practice.

Dr. Rathna Isaac is a clinical psychologist with experience in psychiatric hospital and private practice settings. She is currently a private practitioner. She has written and spoken about ethical issues in Clinical Psychology practice at various forums.

VS- Creating a more globally inclusive bioethics

Venue: Main Auditorium Meeting Room 2

Bebe Loff in association with **Anant Bhan, Aamir Jafarey, Amar Jesani, Farhat Moazam, Sandhya Srinivasan, and Vina Vaswani (listed alphabetically)**

The idea for this workshop arose as a result of ongoing discussion between the above-mentioned individuals concerning the features of low income, developing country settings for which normative global ethical standards, as currently articulated, are not necessarily a good fit.

This workshop will begin with a panel of 4 speakers who will offer their views on this topic and present examples of difficulties that are apparently not addressed by existing ethical principles. Each speaker will address the group for no longer than 5 minutes. Then the input of all present will be sought regarding the validity of the hypothesis and, if time allows, the means by which it might be researched and addressed.

There are many, often overwhelming pressures on doctors that make it a daily challenge to provide care "ethically". These (social, cultural, religious, physical, economic and political) forces require recognition and disentanglement, the nature of their impact in the clinical setting analyzed, and where possible, ethical responses developed. Although guidance will be difficult to devise, there is a need to assist doctors to find an ethical way through the current maze of pressures as well as to advocate for future change.

Please note - there is no desire to throw the baby out with the bathwater – that is to reject valuable and hard won rights. However, it is suggested that current principles are not sufficient to address the range of challenging issues that arise in practice in South Asia. These issues were likely not contemplated in the development of normative ethics to date.

The discussion will identify gaps and difficulties with the application of normative ethical standards, particularly in resource poor settings. The intent is to create a more globally inclusive bioethics.

AUTHORS OF ORAL ABSTRACTS: 5th NATIONAL BIOETHICS CONFERENCE
ARRANGED THEMATICALLY

S.No	Name	Title
Research Ethics – 1		
1	Ms. Shyamala Nataraj South India AIDS Action Programme Mr. Swaminathan Krishnan South India AIDS Action Programme	Minimizing the risk of coercion in healthcare research: Facilitating integrity of informed consent
2	Dr.Akash Shah Research Associate, Department of Physiotherapy, School of Allied Health Sciences, Manipal University, Manipal, India Sathish Rajasekaran Research Associate, Department of Physiotherapy, School of Allied Health Sciences, Manipal University, Manipal, India Dr.Anup Bhat Research Associate, Department of Physiotherapy, School of Allied Health Sciences, Manipal University, Manipal, India Dr.John Solomon Research Associate, Department of Physiotherapy, School of Allied Health Sciences, Manipal University, Manipal, India	Frequency and factors associated with honorary authorship in biomedical Indian journals.
3	Dr. Vina Vaswani, Prof & HOD, Department of bioethics and medical ethics, Yenepoya Medical College , Mangalore. Dr. Ann Thomas Professor, Department of Pediatric Dentistry, A.J. Institute of Dental Sciences, Mangalore	Institutional Ethics Committees Constituents and Compliance With Recommended Ethical Standards In And Around Mangalore – A Pilot
4	Dr S. Swarnalakshmi, Ph.D., IRB Manager, Y R Gaitonde Center for AIDS Dr Anant Bhan Researcher, Bioethics and Global Health Adjunct Visiting Professor, Yenepoya University Dr Prabha Desikan Prof and HOD, Department of Microbiology Bhopal Memorial Hospital and Research Center Dr Medha Joshi HOD, Library Sciences, Tata Memorial Hospital, Mumbai	Maintaining Uniformity in review by Ethics Committees: The importance of Accreditation'
Research Ethics – 2		
5	Dr. Suparna Kanti Pal Clinical Tutor- Institute of Post Graduate Medical Education & Research, Kolkata	Knowledge, Attitude and Practice of researchers about research ethics and laws on clinical trials in a tertiary medical college.
6	Mr.Kelly A Dhru Center for Ethics, Law and Technology, incubated at Gujarat National Law University	The legal rights-based considerations in cervical vaccine trials in India
7	Rev. Dr. J. Charles Davis, Papal Seminary, P. B 3016, Ramwadi Nagar Road, Pune	Embryos: Humans or Biomaterials? Ethics and Law in Human Embryonic Stem Cell Research
8	Dr Shyamala nataraj	Exploring experiences and concerns about

	Dr Krishnan swaminathan South India Aids Action Programme, Chennai	operational and ethical issues involved in AV recordings of informed consent in
Ethics and the Pharma Industry		
9	Dr. Christiane Fischer, MEZIS. Dr.Susan Kamal Abdelrahman, MPH sdtudent, University of Sheffield	The influence of promotional activities of pharmaceutical companies on prescribing habits of physicians in Egypt- a comparison to the situation in western countries and India.
10	Dr. Mohan Isaac President Member SOCHARA	Ethical issues in collaboration with the pharmaceutical industry: How to deal with “conflict of interest”?
11	Dr. Joanna Glajzer Institute for Social Medicine, Epidemiology and Health Economics Charité - Universitätsmedizin Berlin	Existing legal rules regulating conflicts of interests between medical education, research and practice and pharmaceutical industry in Germany
12	Dr.Sarojini N Sama- Resource Group for Women & Health,B-45, 2nd Floor, Main Road Shivalik, Malviya Nagar, New Delhi Dr.Vaibhao Sama- Resource Group for Women & Health,B-45, 2nd Floor, Main Road Shivalik, Malviya Nagar, New Delhi	Corruption in the practices of Central Drugs Standard Control Organization (CDSCO): findings from 59 th Parliamentary Standing Committee Report on Functioning of CDSCO (May 2012)
Public Health Ethics -I		
13	Dr. Angus Dawson, Professor of Public Health Ethics, Headf of Medicine, Ethics, Society & History (MHESH),90, Vincent Drive, School of Health & Populatin Sceinces,College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham , UK	A Critique of Extractive Capitalism: The Role of Public Health Ethics
14	Dr. Eric J Suba, Visiting Scholar, National Center for Bioethics, Tuskegee University, Tuskegee, Ala Director of Clinical Laboratories, Kaiser Permanente Medical Center, San Francisco, California President and Executive Director, The Viet/American Cervical Cancer Prevention Project, San Francisco	US-funded Measurements of Cervical Cancer Death Rates in India: Scientific and Ethical Concerns
15	Dr.Suranjeen Prasad Pallipamula Public Health Resource Network Dr.Haldhar Mahto Public Health Resource Network Dr.Vandana Prasad Public Health Resource Network Dr.Ganapathy Murugan Public Health Resource Network	Ethical Considerations Of Community Health Workers In Jharkhand

Public Health Ethics -2		
16	<p>Dr Chandrashekar J PHD, MS, MDS, DNB Professor Department of Public Health Dentistry Amrita School of Dentistry, Edapally Ernakulum - 682026</p> <p>Dr. Farheen Taha Amrita School of Dentistry AIMS campus, Ponekkara 682041 Edapally, Cochin Kerala Second year post graduate student Department of Public Health Dentistry Amrita School of Dentistry AIMS, Cochin Kerala</p>	Ethics of Dental Health Screening in communities in India
17	<p>Dr.Chandi Prasad Nanda Chandi Prasad Nanda, Professor & HOD Department of History Ravenshaw University, Cuttack, Odisha</p> <p>Dr. Angus Dawson Professor of Public Health Ethics Head of Medicine, Ethics, Society & History (MHESH) 90, Vincent Drive School of Health & Population Sciences College of Medical and Dental Sciences University of Birmingham Edgbaston, Birmingham , UK</p>	Polio eradication in India: a national mission? Exploring some ethical issues through a case study in Odisha, India
18	<p>Dr.Sridevi Seetharam, Bioethicist and Pathologist Dr.Manohar Prasad, Senior Manager, Community Health Activities Dr.Seetharam M R, Program Head (Health)</p>	Financial Inclusion is an ethical imperative to reduce health inequities and strengthen integrity in health schemes
19	<p>Dr.Giridhar R Babu. MBBS, MBA, MPH, PhD. Associate Professor, Public Health Foundation of India, IIPH-H, Bangalore campus, SIHFW premises, Beside leprosy hospital, 1st cross, Magadi road. Bangalore</p> <p>Dr.Sathyanarayana TN Public Health Foundation of India, IIPH-H, Bangalore campus, SIHFW premises, Beside leprosy hospital, 1st cross, Magadi road. Bangalore</p> <p>Dr.Anant Bhan, Public Health Foundation of India, IIPH-H, SIHFW premises</p> <p>Dr.J K Lakshmi, Public Health Foundation of India, IIPH-H, SIHFW premises</p> <p>Dr.Megha Kishore Public Health Foundation of India, IIPH-H,</p>	Revised National Program for Tuberculosis in India:- The slender split between ethical principles and operational convenience

	SIHFW premises	
Ethics of Care		
20	<p>Dr. Poornima Bhola Associate Professor, Department of Clinical Psychology NIMHANS Bangalore, India</p> <p>Dr. Ananya Sinha, PhD scholar, Department of Clinical Psychology, NIMHANS, Bangalore Suruchi Sonkar, PhD scholar, Department of Clinical Psychology, NIMHANS, Bangalore Dr. Ahalya Raguram, Professor, Department of Clinical Psychology, NIMHANS, Bangalore</p>	Ethical Dilemmas experienced by Clinical Psychology Trainee Therapists
21	<p>Dr. Sr. Catherin Nisha PG, Community Medicine, SJMC.</p> <p>Dr. Johnson AR Associate Professor, Department of Community Health. St. John's Medical College, Bangalore</p>	Ethical dilemmas in care of patients admitted to a palliative care unit in South India: A Qualitative Study
22	Dr. Joseph M. Sawyer Keppel St, Bloomsbury, London WC1E 7HT	To Care or Cure? Responding to drug resistant TB (M/XDR-TB) and the role for palliative care.
23	Dr. Thomas Alexander Dean - Medical Education Pondicherry Institute of Medical Sciences Pondicherry	Isn't Integrity in Medical Practice a Utopian Dream in the Society of Today?
Ethics of Disclosure		
24	Dr. Meghna Mukherjee M.Phil Clinical Thinking and Psychotherapy School of Human Studies Ambedkar University, Delhi	Relooking At The Need For Disclosure: The Play of "Knowing" & "Not-Knowing" In The Terminally Ill.
25	<p>Dr. Priya Sreedaran, Assistant Professor, Psychiatry, St John's Medical college and Hospital, Bangalore</p> <p>Dr. Bala Shanthi Nikketha Erstwhile Psychiatric Social Work Consultant, St John's Medical College and Hospital, Bangalore</p>	Revelations and Disclosures: Ethical dilemmas arising in context of imparting psychoeducation to spouse of mentally ill person
26	Dr. Supriya Subramani Research Scholar Department of Humanities and Social Sciences, IIT Madras Chennai	Truth Telling and Therapeutic Privilege: Exploring the Conflicts
27	<p>Dr. Ketaki Hate Research Officer, SNEHA, Mumbai Ms. Sanna Meherall Research Officer, SNEHA, Mumbai, Ms. Neena Shah More Research Officer, SNEHA, Mumbai, Ms. Anuja Jayaraman Research Officer, SNEHA, Mumbai, Mr. David Osrin UCL Institute for Global Health, Guilford Street, London WC1N 1EH, UK</p>	Examining the views of stakeholders in low-income settings on how public health research data should be shared.
Trust, Integrity and Stigma		
28	Dr. Shweta Krishnan Project Associate Wellcome Trust Project On Medical Ideas, Tools and Ethics Dept. Of Humanities and Social Sciences IIT Madras	Interpreting Trust Within The Paradigm Of Autonomy.

29	<p>Mrs. Manjulika Vaz Health and Humanities, St. John's Research Institute, Bangalore</p> <p>Ms.Sandra Travasso Division of Epidemiology, St. John's Research Institute, Bangalore</p> <p>Dr.Mario Vaz Health and Humanities, St. John's Research Institute Department of Physiology, St. John's Medical College, Bangalore</p>	The ethical construct of Stigma: implications in training of health care professionals
30	<p>Ms.A.Samsul Nisha Fatima Final Professional BSMS Student, Government Siddha Medical College, Palayamkottai, Tirunelveli.</p> <p>Ms.M. Dhivya, Final Professional BSMS Student, Government Siddha Medical College, Palayamkottai, Tirunelveli.</p> <p>Ms.S. Merish Final Professional BSMS Student, Government Siddha Medical College, Palayamkottai, Tirunelveli.</p> <p>Ms.N.S. Priya devi, Final Professional BSMS Student, Government Siddha Medical College, Palayamkottai, Tirunelveli.</p>	Regaining People's Trust Through Traditional Siddha Ethical Practices.
31	<p>Mr.M. Tamizhamuthu Final Professional BSMS, Govt. Siddha Medical College, Palayamkottai. Tirunelveli</p>	Achieving Physician Integrity through Traditional Siddha Medical ethics.
Ethics and Reproductive Health		
32	<p>Dr.Sarojini NB</p> <p>SAMA Resource Group for Women and Health</p>	Dying to Give Birth: The Case of Yuma Sherpa and the Unethical Medical Terrain of Assisted Reproductive Technologies
33	<p>Dr.Deepa Venkatachalam, Sama Resource Group for Women and Health</p>	Ethical Imperatives: Bodily integrity in the case of Surrogates
Clinical Ethics		
34	<p>Dr. Smitha Nizar</p>	The Medical Ethics of nondirective counselling and genetic Counselling: Medicine or Ethics?
35	<p>Dr. Rema Devi, Professor, Division of Human Genetics, St.John's Medical College, Bangalore</p>	Ethical Dilemmas In Genetic Counselling
36	<p>Dr.Tharun Varghese Jacob</p> <p>Associate Professor, Department Of Oral And Maxillofacial Pathology, Sri Sankara Dental College, Varkala - Trivandrum, Kerala'</p>	"KNOW THY SPIT"
37	<p>Dr. Vijaya prasad Gopichandran</p> <p>Doctoral Research Fellow, School of Public Health, SRM University,</p>	

	Kattankulathur, Kancheepuram, District, Tamil Nadu Dr. Satish Kumar Chetlapalli Doctoral Research Fellow, School of Public Health, SRM University, Kattankulathur, Kancheepuram, District, Tamil Nadu	In thee I trust' – a survey of trust in physicians in Tamil Nadu
Corruption in Health care and research		
38	Dr.Sarojini N Sama- Resource Group for Women & Health,B-45, 2nd Floor, Main Road Shivalik, Malviya Nagar, New Delhi Dr.Vaibhao Sama- Resource Group for Women & Health,B-45, 2nd Floor, Main Road Shivalik, Malviya Nagar, New Delhi	Corruption in the practices of Central Drugs Standard Control Organization (CDSCO): findings from 59 th Parliamentary Standing Committee Report on Functioning of CDSCO (May 2012)
39	Dr.Thomas M. Walter Lecturer, Dept. of Pharmacology, Govt. Siddha Medical College, Palayamkottai, Tamilnadu. Dr.R. Sweety Nirmala Dept. of Pharmacology, Govt. Siddha Medical College, Palayamkottai, Tamilnadu. Dr.S. Merish, Dept. Of Pharmacology, Govt. Siddha Medical College, Palayamkottai, Tamilnadu. Dr.M. Tamizhamuthu, Dept. Of Pharmacology, Govt. Siddha Medical College, Palayamkottai, Tamilnadu.	Views of Medical Students on Corruption – Lessons from the field
40	Mr.Edward Premdas Pinto Centre for Health and Social Justice Dr. Abhijit Das Centre for Health and Social Justice Director Research and Advocacy, Centre for Health and Social Justice, Delhi.	Ethics deficit health care institutions – An ethical analysis of the institutional behavior based on the selected case studies
41	Dr.Manivelan Rajamanickam Medical Officer, Directorate of Public Health & Preventive Medicine(DPH&PM), DMS Complex, Teynampet, Chennai Dr.Tmt.Kalaivani Medical Officer, Directorate of Public Health & Preventive Medicine(DPH&PM), DMS Complex, Teynampet, Chennai	Corruption in public health systems: An overview
Ethics and Gender		
42	Dr. Nilangi Sardeshpande Pursuing PhD at TISS, Mumbai.	Hysterectomy among premenopausal women- how informed is the decision to undergo hysterectomy?
43	Dr. Rupali Jain ENT Consultant, Member and Co- Treasurer Of Anandi NGO	Ethical challenges faced while providing care to survivors of domestic violence in routine medical practice in a town in Maharashtra

44	Dr.Deepa V Dr. Nazia Hassan Sama Resource Group for Women and Health	Interrogating Health Care Response to Gender Based Violence: Implication for Health Care Integrity
45	Dr. Sunita Chowdhury Programme Coordinator Sama- Resource group for Women and Health, New Delhi	Enhancing Adolescent Sexual and Reproductive Health and Rights (SRHR) through Health Systems Engagement

LIST OF Poster Abstracts ACCEPTED FOR 5TH NATIONAL BIOETHICS CONFERENCE

S.No	Name	Title
1	<p>Dr. Tom Mishael 2nd MBBS Batch of 2012 St. John's medical college Bangalore -34 tommishael@gmail.com</p> <p>Dr. Mario Vaz St. John's Medical College, ³ Health and Humanities, St. John's Research Institute, Bangalore -560034, India</p>	A historical evaluation of the discourse on ethics in medical education in India between 1915 and 1965.
2	<p>Dr.Adithya Pradyumna Research and Training Assistant, SOCHARA, Bangalore</p>	Genetically modified food crops – an ethics enquiry into the policy process and stakeholder concerns
3	<p>Dr. Jean Fredrick Department of Physiology, St.John's Medical College, Bangalore-560034</p>	Plagiarism Check Using Easily Accessible Software - A Personal Experience
4	<p>Dr Jayakrishnan Thayyil. Associate Professor , Dept of Community Medicine, Govt Medical College Kozhikode. Kerala.</p> <p>Dr. Vidya Kuniyil. Associate Professor, Govt Medical College Kozhikode.</p>	Ethics of Using Type 2 Oral Polio Vaccine In India
5	<p>Dr. K. Leena Pramod , Yenepoya Medical College, Yenepoya University, Mangalore, Karnataka curator@yenepoya.edu.in</p> <p>Dr.Vina Vaswani Director, Centre for Ethics, Yenepoya University, Mangalore, Karnataka</p> <p>Dr.Ravi Vaswani Professor, Dept. of Internal Medicine, Yenepoya Medical College, Yenepoya University, Mangalore, Karnataka</p>	Knowledge, attitude and practice of physicians with respect to four principles of bioethics vis-à-vis the knowledge and perception
6	<p>Dr.Anup Bhat, MPT Department of physiotherapy, M S Ramaiah Medical College, Bangalore, India</p> <p>Mr.Akash Shah, MPT² Department of Physiotherapy, School of Allied Health Sciences, Manipal University, Manipal, India</p> <p>Ms. Swathi GS, MPT Physiotherapy Unit, Mahesh Hospital, Udupi, India.</p>	Instructions to authors provided in biomedical Indian journals
7	<p>Dr.Johnson Pradeep. R Assistant Professor, Department of Psychiatry, Ethics, Institutional Ethics Committee and Human Research Protection Programme, St.John's Medical College Hospital, Bangalore</p>	Upholding Patient's Confidentiality – An Experiential account of a Psychiatrist's Plight
8	Dr Sripada G Mehandale,	Informed consent in medical research:

	<p>Professor, Department of Anaesthesiology, K S Hegde Medical Academy, Deralakatte, Mangalore</p> <p>Dr. Uma Kulkarni, Professor, Department of Ophthalmology, Yenepoya Medical College, Deralakatte, Mangalore</p> <p>Prof. Dr. Vina Vaswani, Director, Centre for Ethics, Yenepoya University, Deralakatte, Mangalore</p>	perceptions among medical students : A survey
9	<p>Dr. Nilima Shah, Assistant Professor, Psychiatry, Government Medical College, Surat</p> <p>Dr Ritarabhara Mehta,</p> <p>Dr Kamlesh Dave</p>	Sensitizing intern doctors to ethical issues in a doctor-patient relationship
10	<p>Dr.Swapnil S Agarwal, Professor & Head,Department of Forensic Medicine & Toxicology,Pramukhswami Medical College & SKHospital,Karamsad, Anand, Gujarat</p>	Assessment of Knowledge On Bioethics In Medical Students And Teaching Staff and Their Perception On Bioethics As A Subject

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